MACRA, MIPS AND BPCI

Health Policy & Reimbursement
MACRA
THE MEDICARE ACCESS & CHIP REAUTHORIZATION ACT
WHAT IS MACRA?

- Repeals the Sustainable Growth Rate formula
- Reimburse clinicians for value rather than volume
- Condenses quality programs under the Merit Based Incentive Payment System (MIPS)
- Requires Medicare to remove SSN from Medicare cards
- Clinicians participating in alternative payment models (APMs) eligible for bonus payments
WHAT IS MACRA?

- **MIPS**: Merit-Based Incentive Payment System (Budget Neutral)
- Incentive payments for participation in Advanced Alternative Payment Models (APMs)
- Physicians can opt out of the MIPS track if they participate in an APM
- Physician practices exempt with less than $90,000 in Medicare charges (excludes Part B Drugs), fewer than 200 professional services under PFS or fewer than 200 Medicare patients per year

The rule implements these changes through a framework called the “Quality Payment Program” which has 2 paths:

- The Merit-based Incentive Payment System (MIPS)
- OR
- Advanced Alternative Payment Models (APMs)
MIPS
MERIT-BASED INCENTIVE PAYMENT SYSTEM
MIPS

- Promotes better care, healthier people, and smarter spending
- Evaluates EP’s using a composite score that incorporates performance on quality, resource use, clinical practice improvement activities and meaningful use of EHR
- EPs may receive upward payment, downward payment or no payment adjustment
- Most practitioners will be subject to MIPS
- Payment adjustments begin in 2019 based on 2017 starting data
- Years 1 and 2 (2017 and 2018) include MDs, PAs, NPs, Clinical Nurse Specialists, Nurse Anesthetists, clinician group that has at least one of the professionals listed
- Years 3+ include Physical/Occupational Therapists, Speech Pathologists, Audiologists, Midwives, Social Workers, Psychologists, Dietitians
WHO WILL NOT PARTICIPATE IN MIPS?

- First year of Medicare Part B participation
- Below low patient volume threshold (Medicare billing charges less than or equal to $90k OR 200 or fewer Medicare beneficiaries in a 12 month period
- Certain providers participating in Advanced Alternative Payment Models (APMs)

MIPS DOES NOT apply to hospitals or facilities
## PENALTY FOR NON-PARTICIPATION

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Medicare Part B Payment Year Adjustment</th>
<th>Maximum -% MIPS Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>2019</td>
<td>-4%</td>
</tr>
<tr>
<td>2018</td>
<td>2020</td>
<td>-5%</td>
</tr>
<tr>
<td>2019</td>
<td>2021</td>
<td>-7%</td>
</tr>
<tr>
<td>2020</td>
<td>2022</td>
<td>-9%</td>
</tr>
</tbody>
</table>

## PAYMENT FOR NON-ELIGIBLE CLINICIANS

- 0.5% increase until 2019
- No increase and 0% conversion factor after 2019 – 2025
- Annual adjustment of +0.25% in 2026 and thereafter
WHAT DETERMINES MIP SCORE?

**QUALITY** – (45%)
Based on reporting of 6 of 300 measures required under the Physician Quality Reporting System

**COST** – (15%)
Based on claims data
- Total Per Capita Cost and Medicare Spending Per Beneficiary (MSPB)
- Eight episode-based measures

**CLINICAL PRACTICE IMPROVEMENT ACTIVITIES** – (15%)
Based on attestation
- Select activities from 112 options (care coordination, beneficiary engagement, patient safety)

**PROMOTING INTEROPERABILITY (PI)** – (25%)
Report customized measures that reflect how you use EHR in day-to-day practice

**BONUS POINTS**
Small practice and complex patient complexity
QUALITY REPORTING MEASURES (45%)

For individual clinicians
- Qualified Registry
- Qualified Clinical Data Registry (QCDR)
- Claims
- Electronic Health Records (EHR)

For groups
- Qualified registry
- Qualified clinical data registry (QCDR)
- CMS web Interface
- Electronic Health Records (EHR)

- If reporting through EHR, QCDR or qualified registry, at least 60% of all payer patients or visits must be reported
- If reporting through claims, at least 60% be Medicare patients/visits
- If reporting through CMS Web Interface, at least 248 Medicare patients will be randomly selected to be reported on each measure
COST REPORTING MEASURES (0%)

- 15% in 2019 payment year
- 2020 payment year and beyond – cost measure will be between 10% and 30%

- Includes Medicare Spending per Beneficiary (MSPB)
- CMS developing episode-based measures
- CMS will calculate from claims data
CYCLE OF THE PROGRAM FOR 2021 PAYMENT

PERFORMANCE
Quality data from January 1, 2019 through December 31, 2019

DATA SUBMISSION
Deadline for sending in data

ADJUSTMENT
Date MIPS payment adjustments begin

Medicare gives you feedback about your performance

2019
March 31, 2020
January 1, 2021
ADVANCED APM’S

To be an “Advanced APM” you:

- Must be a CMS Innovation Center Model, in a Shared Savings Program Track or be involved in certain federal demonstration programs
- Must base payment on quality measures (comparable to those in MIPS)
- Must have at least 50% of eligible clinicians in each APM entity use EHR
- Must bear more than a nominal financial risk from monetary losses or be a Medical Home Model

  To achieve the “nominal risk” threshold the APM must be at risk for 8% of the average estimated total Medicare A & B revenues of participating APM entities 3% of the expected expenditures for which an APM entity is responsible

- If an APM’s expenditures exceed expectations during a performance year CMS can:
  - Withhold payment to the APM entity and/or the APM’s eligible clinicians;
  - Reduce payment rates to the APM and/or the APM’s eligible clinicians; or
  - Require the APM to owe payment(s) to CMS

Would receive 5% incentive payment

CMS will re-open applications for new practices and participants to participate in APMs
CMS RESOURCES

https://qpp.cms.gov/

https://qpp.cms.gov/about/resource-library

https://qpp.cms.gov/apms/overview

BPCI
BUNDLED PAYMENTS FOR CARE IMPROVEMENT
Bundling is a single payment for an array of services

- Bundled payments set a payment amount for a period or episode of care
- Bundled episodes are tied to a procedure or treatment for a particular condition
- The bundled payment is the target to achieve for providers, which shifts risk from the payer to the provider thereby creating incentives for efficiencies
- Participants are financially incentivized to reduce duplication, prevent avoidable utilization, and provide more cost effective care
- Bundles can align incentives across many providers when they share the incentives

<table>
<thead>
<tr>
<th>Bundled Payment Amt.</th>
<th>Spending During Bundle</th>
<th>Historical Spending</th>
</tr>
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<tbody>
<tr>
<td>$9,000</td>
<td>$8,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>$10,000</td>
<td>$8,000</td>
<td>$2,000</td>
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<tr>
<td>$9,000</td>
<td>$8,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>
Because bundled payments are lower than the sum of individual payments to providers, participants can only succeed by providing more efficient care, which may sometimes be at odds with providing optimal care.

**Key Considerations**

<table>
<thead>
<tr>
<th>$Goal</th>
<th>Maximize efficiency within a specific bundle</th>
</tr>
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<tbody>
<tr>
<td>Approach</td>
<td>Use least costly supplies, equipment; identify partners to reduce high cost service use (e.g., hospital readmissions)</td>
</tr>
<tr>
<td>Tools</td>
<td>Administrative function to coordinate across providers, IT infrastructure, provider partnerships</td>
</tr>
<tr>
<td>Target Patients</td>
<td>Varies by bundle; most common for procedure-based episodes (e.g., hip surgery), less common for complex chronic care episodes (e.g., diabetes)</td>
</tr>
<tr>
<td>Key Questions</td>
<td>Do bundles appropriately capture physician clinical choice and individual patient variability? Can bundle capture full breadth of costs for an episode?</td>
</tr>
</tbody>
</table>
# BPCI VOLUNTARY MODELS

<table>
<thead>
<tr>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
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<tbody>
<tr>
<td><strong>Episode</strong></td>
<td><strong>Inpatient stay plus the post-acute care up to 90 days post discharge</strong></td>
<td><strong>Triggered by inpatient stay but begins at initiation of post-acute care services with a SNF, IP rehab facility, long-term care hospital or home health agency</strong></td>
</tr>
<tr>
<td><strong>All participants</strong></td>
<td>699</td>
<td>1133</td>
</tr>
</tbody>
</table>

[https://innovation.cms.gov/initiatives/bundled-payments/](https://innovation.cms.gov/initiatives/bundled-payments/)
BPCI ADVANCED

- Voluntary
- Single retrospective bundled payment
- 90 day clinical episode duration
- 29 inpatient clinical episodes
- 3 outpatient clinical episodes
- Qualifies as an Advanced Alternative Payment Model
- Payment is tied to performance on quality measures

29 Inpatient Clinical Episodes:
- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis
- Acute myocardial infarction
- Back & neck except spinal fusion
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- COPD, bronchitis, asthma
- Combined anterior posterior spinal fusion
- Congestive heart failure
- Coronary artery bypass graft
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Hip & femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Major bowel procedure
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Pacemaker
- Percutaneous coronary intervention
- Renal failure
- Sepsis
- Simple pneumonia and respiratory infections
- Spinal fusion (non-cervical)
- Stroke
- Urinary tract infection

3 Outpatient Clinical Episodes:
- Percutaneous Coronary Intervention (PCI)
- Cardiac Defibrillator
- Back & Neck except Spinal Fusion
BPCI ADVANCED TIME LINE

- Application Portal Opens: 1/11/2018
  Closes: 3/12/2018

- CMS Screens Applicants March – June and offers Participant Agreements June 2018

- Signed Participant Agreements and Clinical Episode selections to CMS August 2018

- Model Go Live: 10/1/18

- First date for quality determination: March 31, 2019

- Next Application Period: 1/1/20
COMPREHENSIVE CARE FOR JOINT REPLACEMENT (CJR) EXPANDS BUNDLING FOR LOWER JOINTS

CJR is CMMI’s first mandatory alternative payment model, which builds upon BPCI’s lower joint replacement bundles included in model 2

What is CJR?

1. **Mandatory Program:** CJR is a five-year program beginning in April 2016. It is the first mandatory CMMI demonstration, requiring participation from all hospitals located in 67 MSAs (2018 - only 34 areas)

2. **CJR Episodes:** (90 days) for lower extremity joint replacement cases: MS-DRGs 469 and 470 only

3. **Hospitals Bear Financial Risk:** Hospitals must bear risk for hospital + post-hospital care

Where will it happen?

2018 - Up to 470 hospitals expected to operate under this model (compared to 800 under the old program).


2020 UPDATE CMS issued a proposed rule 2/20/2020 extending the CJR for 3 years
Beginning July 1, 2017, hospitals in 98 randomly selected metro areas across the country will be required to participate in Medicare’s new 5-year mandatory bundle programs for 90-day AMI and CABG episodes. CMS has not yet selected the metro areas that will be included in the mandatory cardiac bundle program.

**Proposed Rule Formally Posted For Comment on Federal Register**

**Comment Deadline**

**Oct. 3, 2016 – Dec 2016**

**Final Rule Posted**

**Dec 20, 2016**

**Bundles Initiated in Select Metro Areas**

**July 1, 2017**

CMS Cancels these 2 mandatory bundled-payment models

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Questions?

Contact our Reimbursement Support Center

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