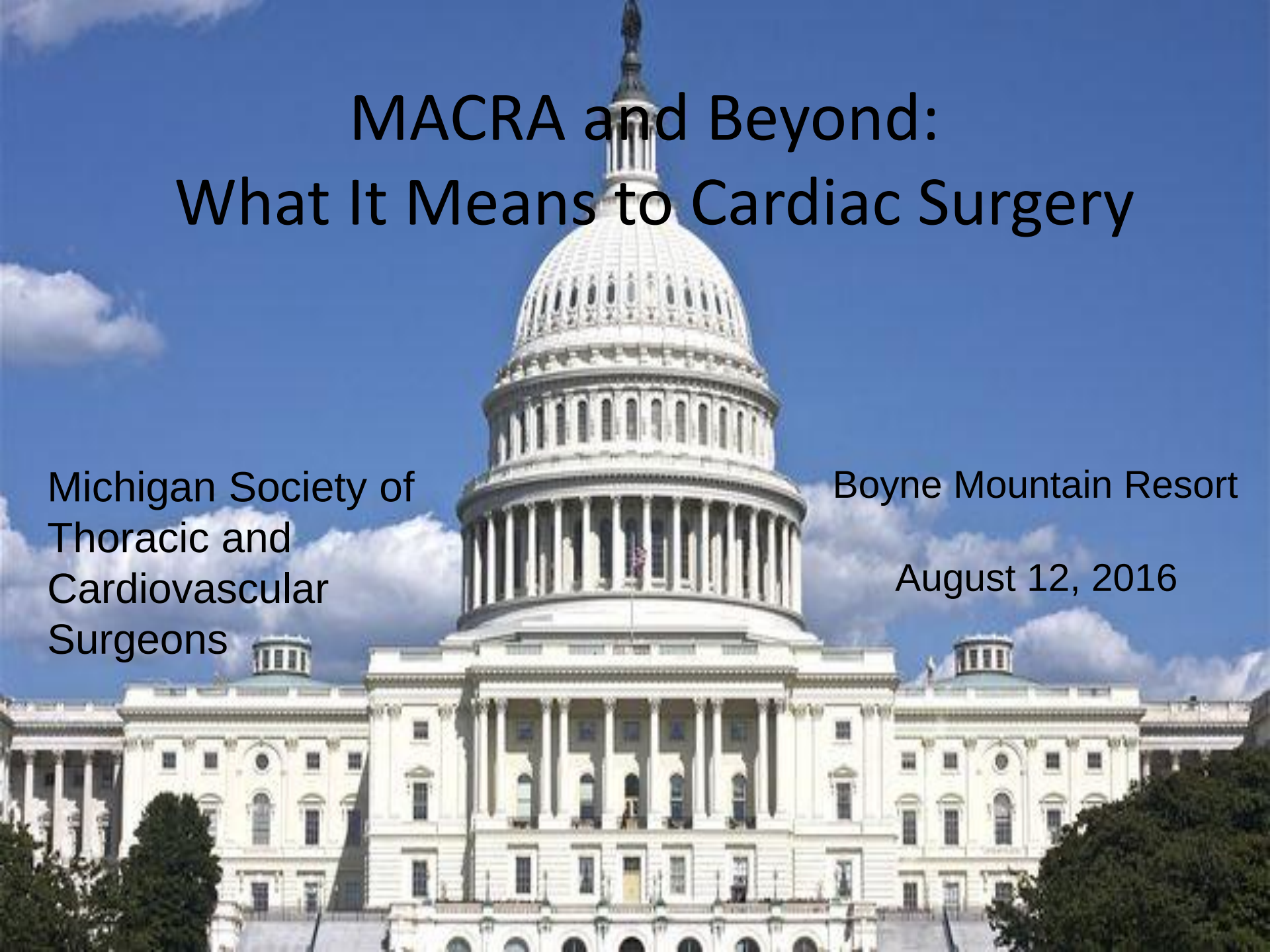

MACRA and Beyond: What It Means to Cardiac Surgery

Michigan Society of Thoracic and Cardiovascular Surgeons

Boyne Mountain Resort

August 12, 2016

Disclosures

Medtronic: North American Cardiac Surgery Advisory Board


FEE For SERVICE

Our World After MACRA

Medicare Access and CHIP Reauthorization Act of 2015

APMs
MIPS

Our World After MACRA

Medicare Access and CHIP Reauthorization Act of 2015

Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B, CY 2017

G Codes
GXXX1-5

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"Mandatory
CABG
Bundle"

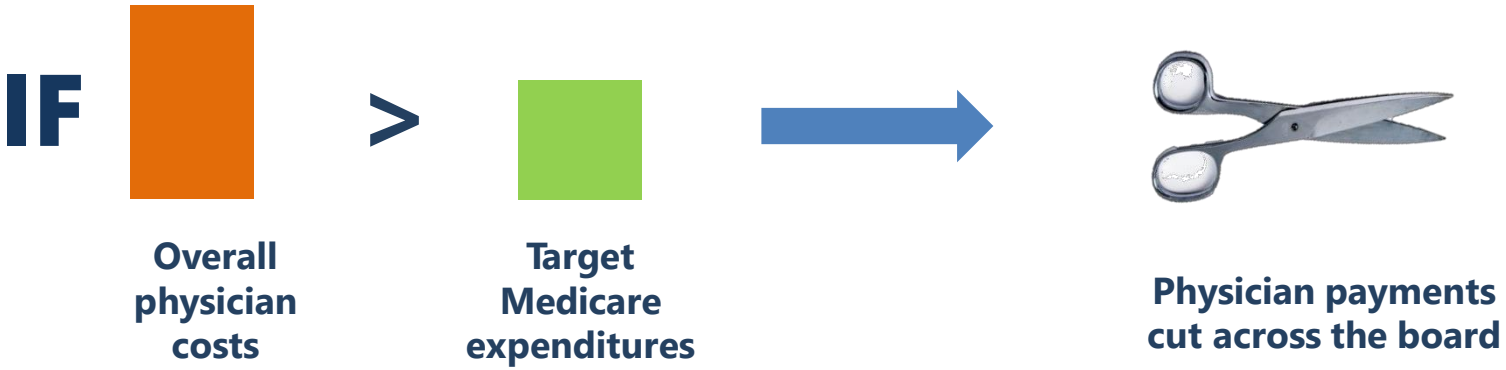
APMs
MIPS

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians



What is “MACRA”?

The **Medicare Access and CHIP Reauthorization Act of 2015**: bipartisan legislation signed into law on April 16, 2015.

MACRA reconfigures the physician payment landscape:

1. Repeals the Sustainable Growth Rate (SGR) formula
2. Changes the way that Medicare rewards physicians for value over volume
3. Streamlines multiple quality programs under the new **Merit-based Incentive Payment System (MIPS)**
4. Incentivizes the development of **Alternative Payment Models (APMs)**
5. Preserves global surgical payments

MACRA Payment Plan

MACRA sets up a fork in the road for physician payment:

MIPS Overview

Consolidating existing quality incentive programs:

Physician Quality Reporting Program **(PQRS)**	Value-Based Payment Modifier	Medicare EHR Incentive Program

MACRA streamlines those programs into **MIPS**:

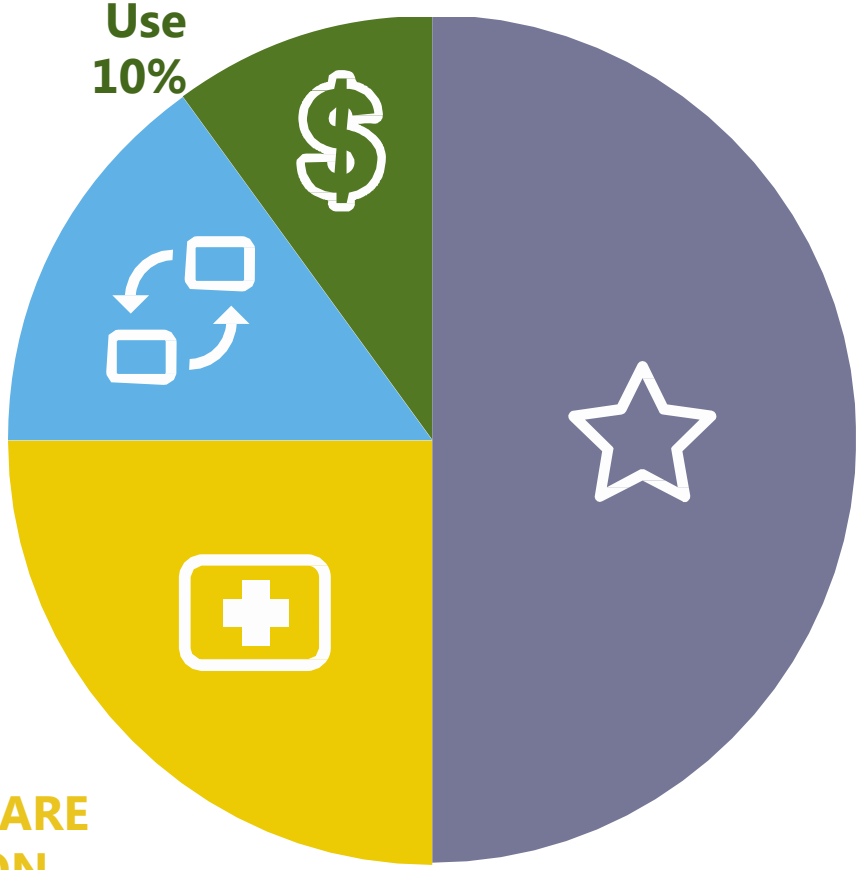
Merit-Based Incentive Payment System
(MIPS)

MIPS Score

Score will factor in performance across four categories:

Quality: PQRS
Resource use: VBM
CPIA: new, Registry

Year 1 Performance Category Weights for MIPS



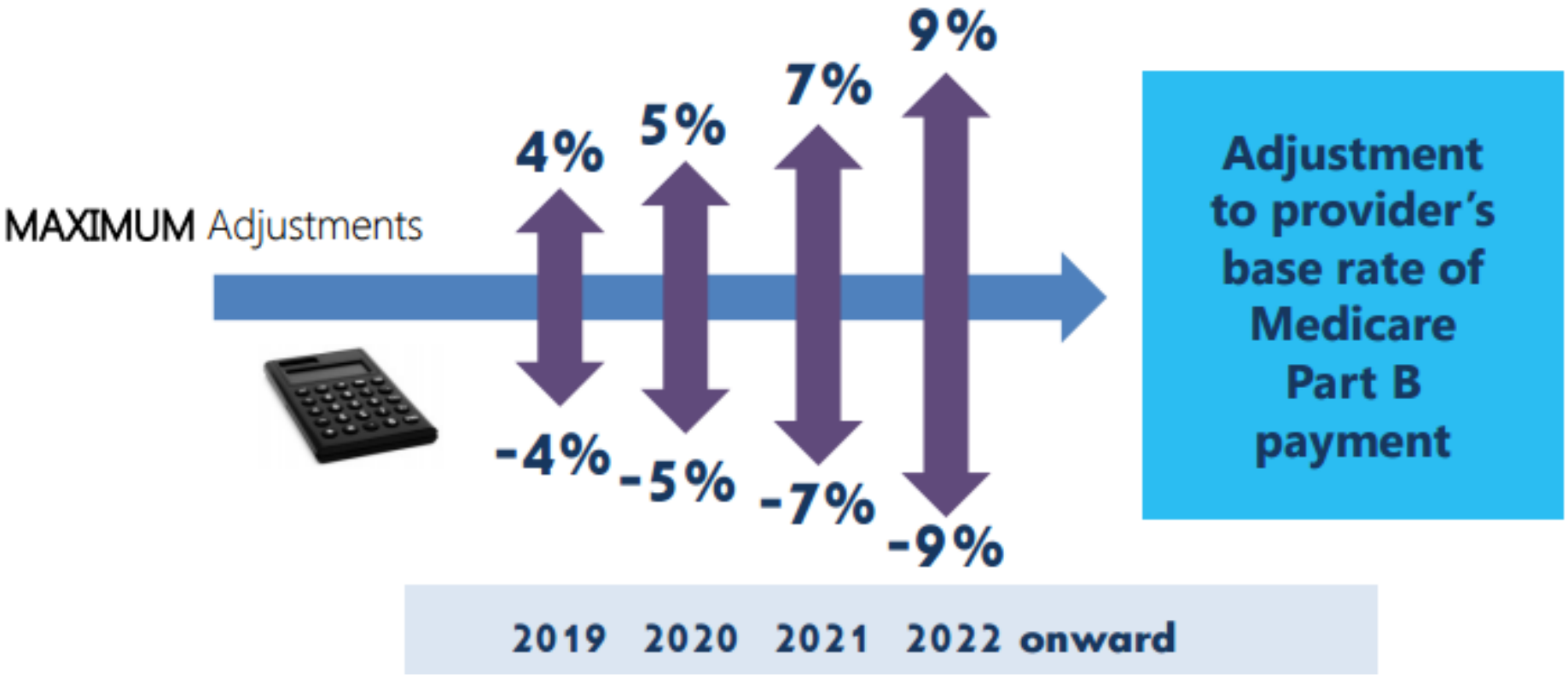
Proposed Rule: MIPS Timeline

2017	2018	July		2019	2020
Performance Period (Jan-Dec) 1st Feedback Report (July)	Reporting and Data Collection	2nd Feedback Report (July)	Targeted Review Based on 2017 MIPS Performance	MIPS Adjustments in Effect	

Analysis and Scoring

MIPS Payment Adjustments

MIPS bonuses and penalties are a zero-sum game:



MACRA aligns with goals previously set by Obama Administration

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

Medicare Fee-for-Service

GOAL 1:

30%

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2:

85%

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

Figure 1. APM Framework (At-A-Glance)

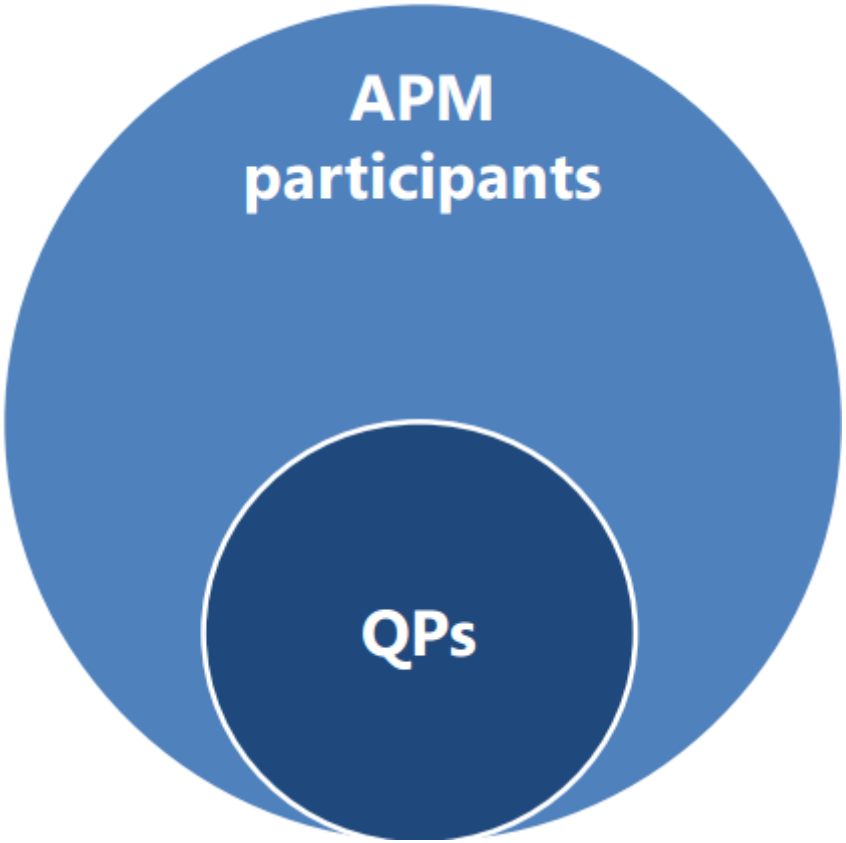
Alternative Payment Models

- *Purpose: Increase quality while reducing cost and resource use.*

MACRA Incentives Nudging Physicians into APMs:

APMs and MACRA

- Only a subset of APMs—those deemed “advanced APMs”—will be Qualified APM Participants (QPs) eligible for the 5% bonus under MACRA.
- All others fall under MIPS.



Advanced Alternative Payment Model(s)

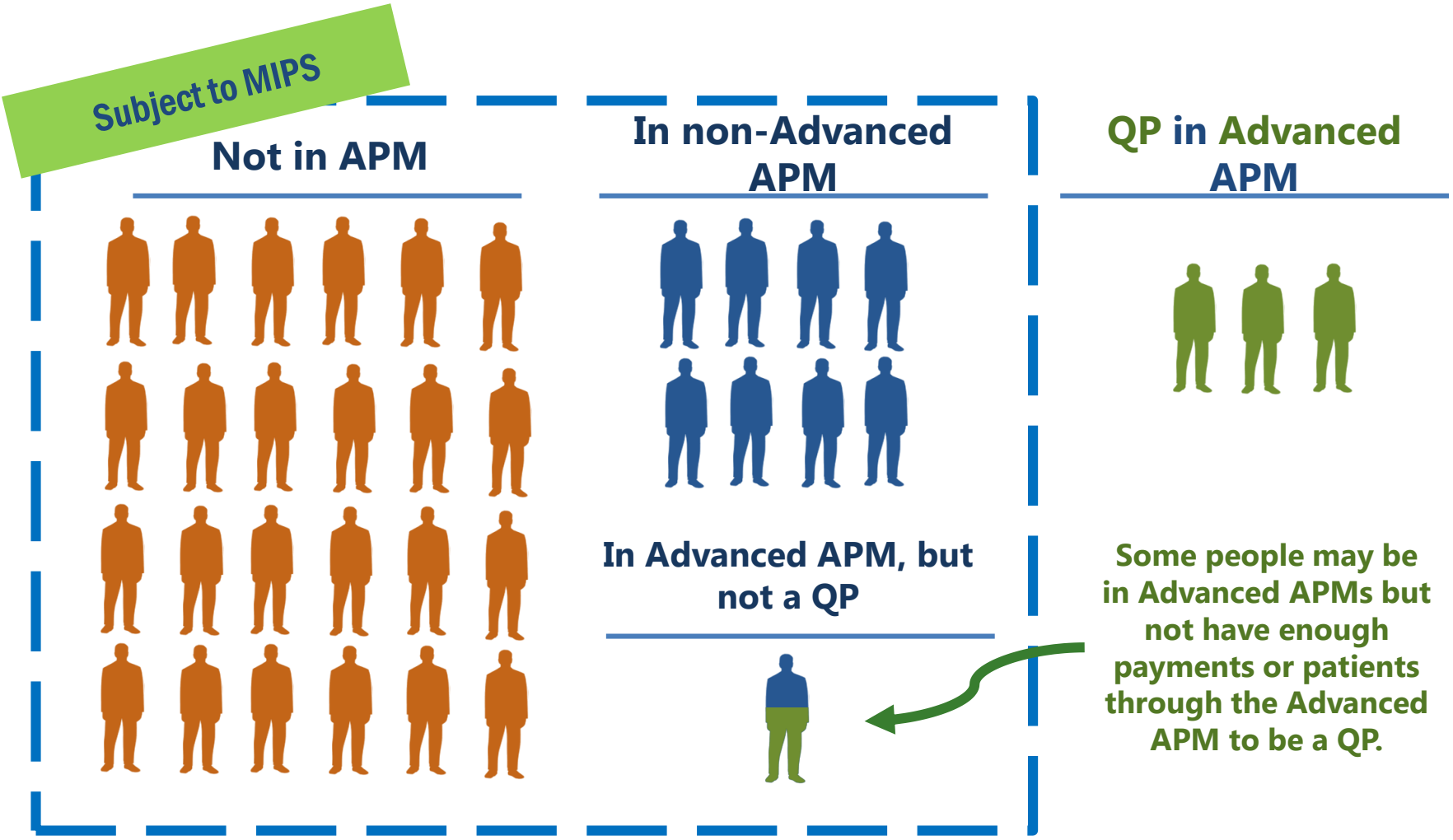
- **Advanced APMs meet the following criteria set forth in MACRA:**

✓ Base payment on quality measures similar to those in MIPS

✓ Use of certified EHR

✓ Bear "more than nominal" risk

Most clinicians will be subject to MIPS.



Note: Figure not to scale.

Who Designs and Reviews an APM?

- Physician-focused Payment Model Technical Advisory Committee (PTAC)

- Health Care Payment Learning and Action Network (HCP-LAN)
- STS in process of becoming “Committed Partner”

- Physicians developing APMs:
  - Brandeis & American College of Surgeons
  - STS White Paper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160989386

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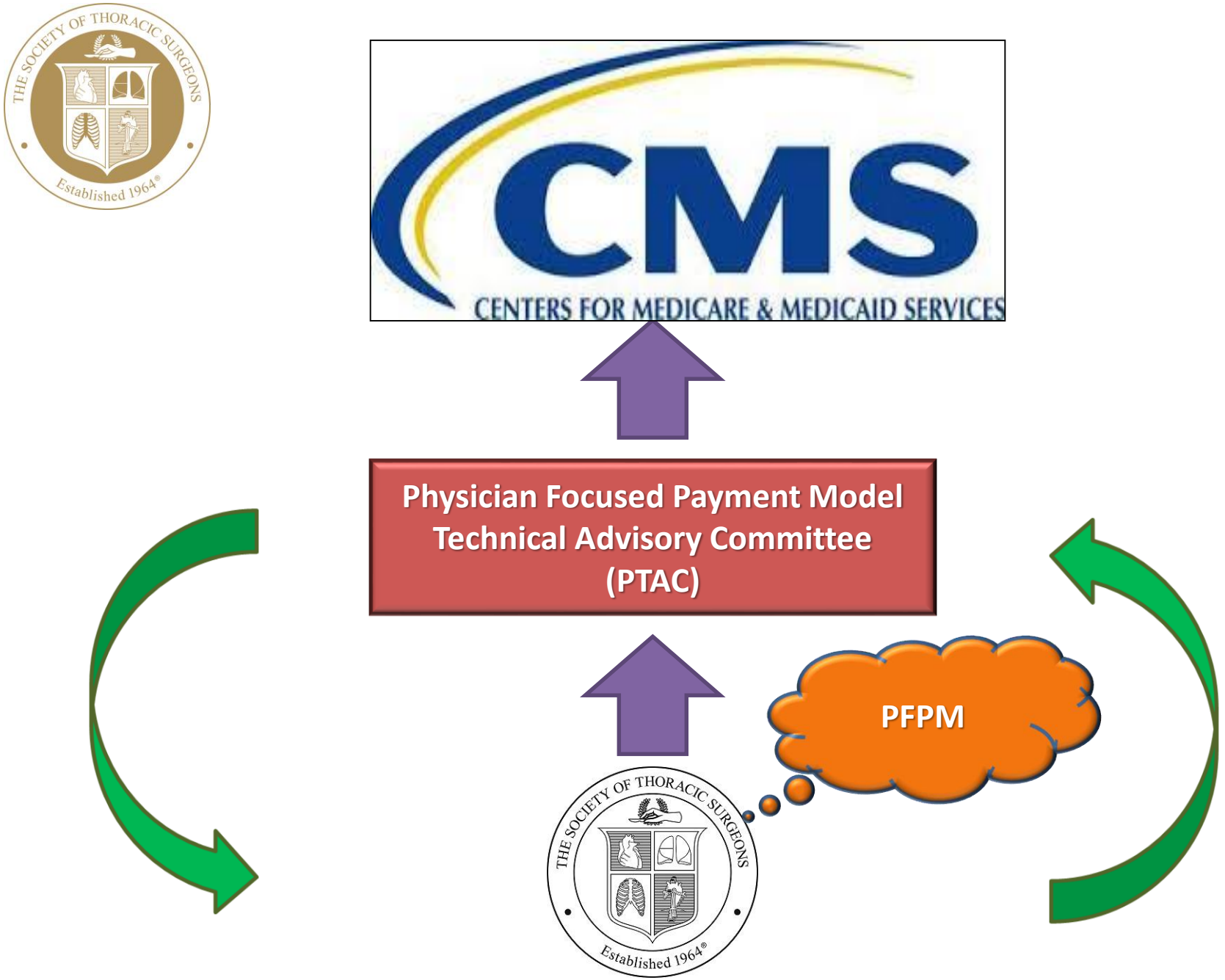


Physician Focused Payment Model

G Codes……GeeWhiz

- Key element of claims-based reporting: using codes that appropriately reflect the services furnished
- Most frequently recommended approach: report the existing CPT code for follow-up visits in the surgical package (CPT 99024 – Postoperative follow-up visit, normally included in the surgical package, to indicate than an E/M service was performed during a postoperative period for a reason(s) related to the original procedure.)

G Codes……GeeWhiz

- “To assist in determining appropriate coding for claims-based reporting, we added a task to the RAND contract for developing a model to validate the RVUs in the PFS
- Modified RAND contract to include development of G-codes that could collect data about post-surgical follow-up visits on Medicare Claims
- This could be included in model for validating RVUs”

G Codes……GeeWhiz

RAND recommended a set of time-based post-operative visit codes that could be used for reporting care provided during the post-operative period

Applied to a REPRSENTATIVE Sample of Surgical Pts.-Time/Intensity Values

G Codes……GeeWhiz

TABLE 9: Proposed Global Service Codes

Inpatient	GXXX1	Inpatient visit, typical, per 10 minutes, included in surgical package
	GXXX2	Inpatient visit, complex, per 10 minutes, included in surgical package
	GXXX3	Inpatient visit, critical illness, per 10 minutes, included in surgical package
Office or Other Outpatient	GXXX4	Office or other outpatient visit, clinical staff, per 10 minutes, included in surgical package
	GXXX5	Office or other outpatient visit, typical, per 10 minutes, included in surgical package
	GXXX6	Office or other outpatient visit, complex, per 10 minutes, included in surgical package
Via Phone or Internet	GXXX7	Patient interactions via electronic means by physician/NPP, per 10 minutes, included in surgical package
	GXXX8	Patient interactions via electronic means by clinical staff, per 10 minutes, included in surgical package

WOULD BE APPLIED TO ALL SURGICAL PROCEDURES!

G Codes……GeeWhiz

What does this mean?

- In MACRA, we were able to block dissolving of 90 day Globals
- CMS didn't like that
- They have gone outside of legislative directives to est G codes, starting Jan 1 2017
- STS is developing strategies with ACS to challenge this Rule and its implementation (Doc Caucus, ACS, Individual lobbying efforts with Congress,etc)
- Education efforts to inform STS members

CMS Proposed Rule for "Mandatory Bundle for CABG"

- Under Social Security Act (Section 1115A) authorizes the Innovation Center-CMS to test innovative payment models
- Fee for Service: separate payments to providers for services
- Amount of payments dependent on Volume; providers may not have incentives to invest in quality-improvement and/or care-coordination services—as result, care may be fragmented or unnecessary
- The Goal of Proposed EPMs: improve quality of care provided to beneficiaries in episodes while reducing spending through Financial Accountability

Episode Payment Models=EPMs

CMS Proposed Rule for "Mandatory Bundle for CABG"

Proposed EPMs:

- Acute Myocardial Infarction (AMI)
- Coronary Artery Bypass Graft (CABG)
- Surgical hip/femur fracture treatment (SHFFT) excluding lower extremity Joint Replacement
- PURPOSE: TEST whether the proposed models would benefit Medicare beneficiaries by improving the coordination and transition of care, encourage more provider investment in infrastructure and redesigned care processes for higher-quality and more efficient service delivery
- Propose to test EPMs for 5 years: July 1,2017-December 31, 2021

Directive to Hospitals for Care Redesign

- Increasing post-hospitalization follow-up and medical mgt. for patients
- Coordinating across the inpatient and post-acute care spectrum
- Conducting appropriate discharge planning
- Improving adherence to treatment or drug regimens
- Reducing readmissions and complications during post-discharge period
- Managing chronic diseases and conditions related to the EPM episodes
- Choosing the most appropriate post-acute care setting
- Coordinating between providers and suppliers such as hospitals, physicians, and post acute-acute care providers

Proposed Models allow CMS to gain Additional Experience with Episode-Payment Approaches

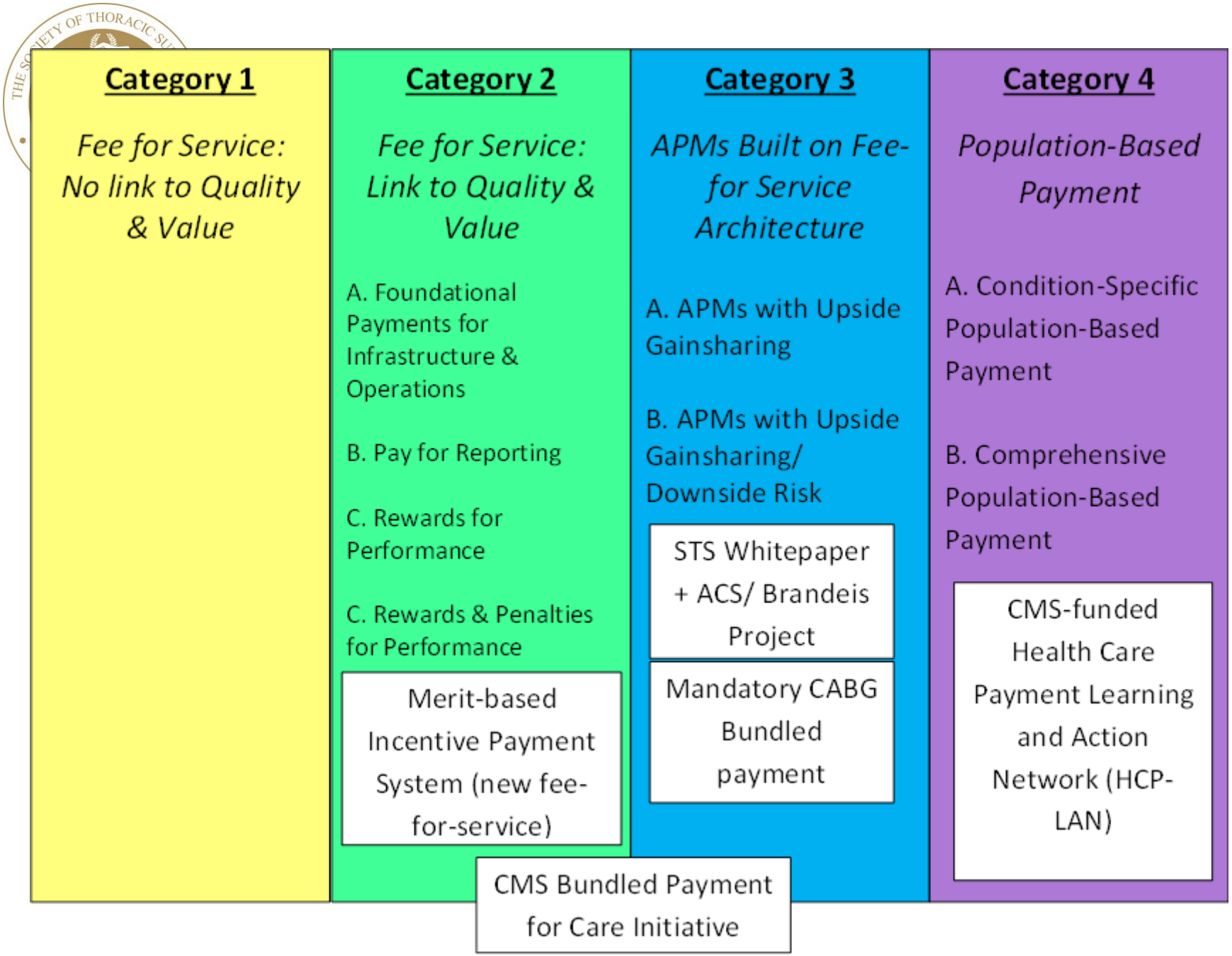
- Variance in historic care and utilization patterns
- Patient population and Care patterns
- Variance in roles within the local markets
- Variance in volumes of services
- Variance in levels of access to financial community
- Variance in levels of population and health-care provider density
- Variations in use of different categories of post-acute care providers

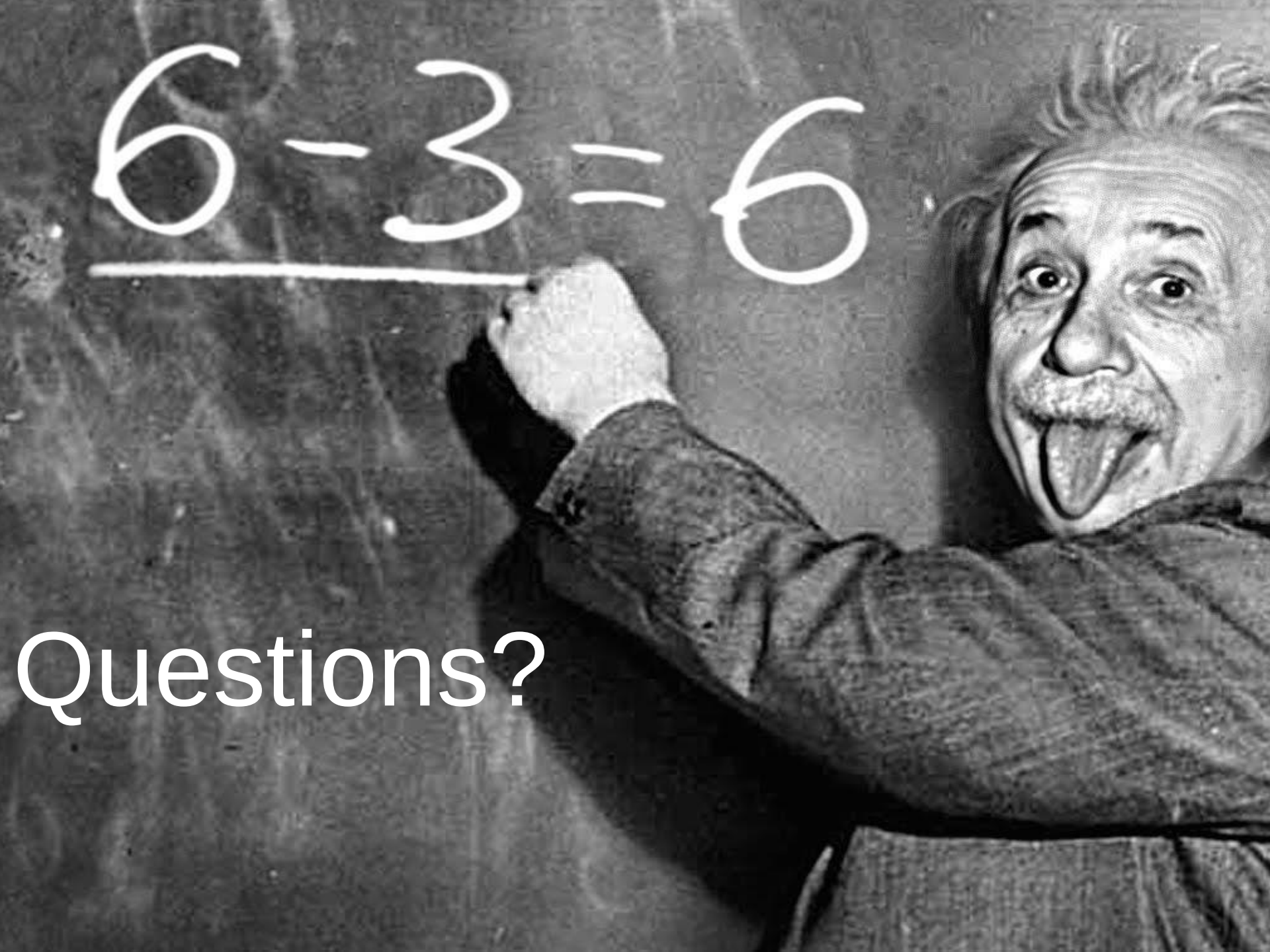
Summary of Payment

- Test will run for 5 years; first yr: July 1,2017
- CMS proposes to continue paying providers usual Medicare FFS payments
- After completion of performance year, the “Medicare claims payments for services furnished to the beneficiary during the episode, based on claims data, would be combined to calculate actual episode payment”
- Such actual payment would be reconciled against est EPM quality-adjusted target price
- If +, would be paid to participant: reconciliation payment. If -,would require repayment from hospital “with episodes ending in 2nd quarter of performance yr 2 of EPM”

Summary of Payment cont.

- EPM participants' quality performance also would be assessed at reconciliation; each participant would receive composite quality score and quality category.
- EPM participants that achieve quality category as "acceptable" or higher are eligible for payment.
- Proposed measures for CABG model: All-Cause,30 Day, Risk-Standardized Mortality Rate following CABG (NQF #2558)


Category 1
Fee for Service: No link to Quality & Value
Category 2
Fee for Service: Link to Quality & Value
A. Foundational Payments for Infrastructure & Operations
B. Pay for Reporting
C. Rewards for Performance
C. Rewards & Penalties for Performance
Merit-based Incentive Payment System (new fee-for-service)
Category 3
APMs Built on Fee-for Service Architecture
A. APMs with Upside Gainsharing
B. APMs with Upside Gainsharing/ Downside Risk
STS Whitepaper + ACS/ Brandeis Project
Mandatory CABG Bundled payment
CMS Bundled Payment for Care Initiative
Category 4
Population-Based Payment
A. Condition-Specific Population-Based Payment
B. Comprehensive Population-Based Payment
CMS-funded Health Care Payment Learning and Action Network (HCP-LAN)



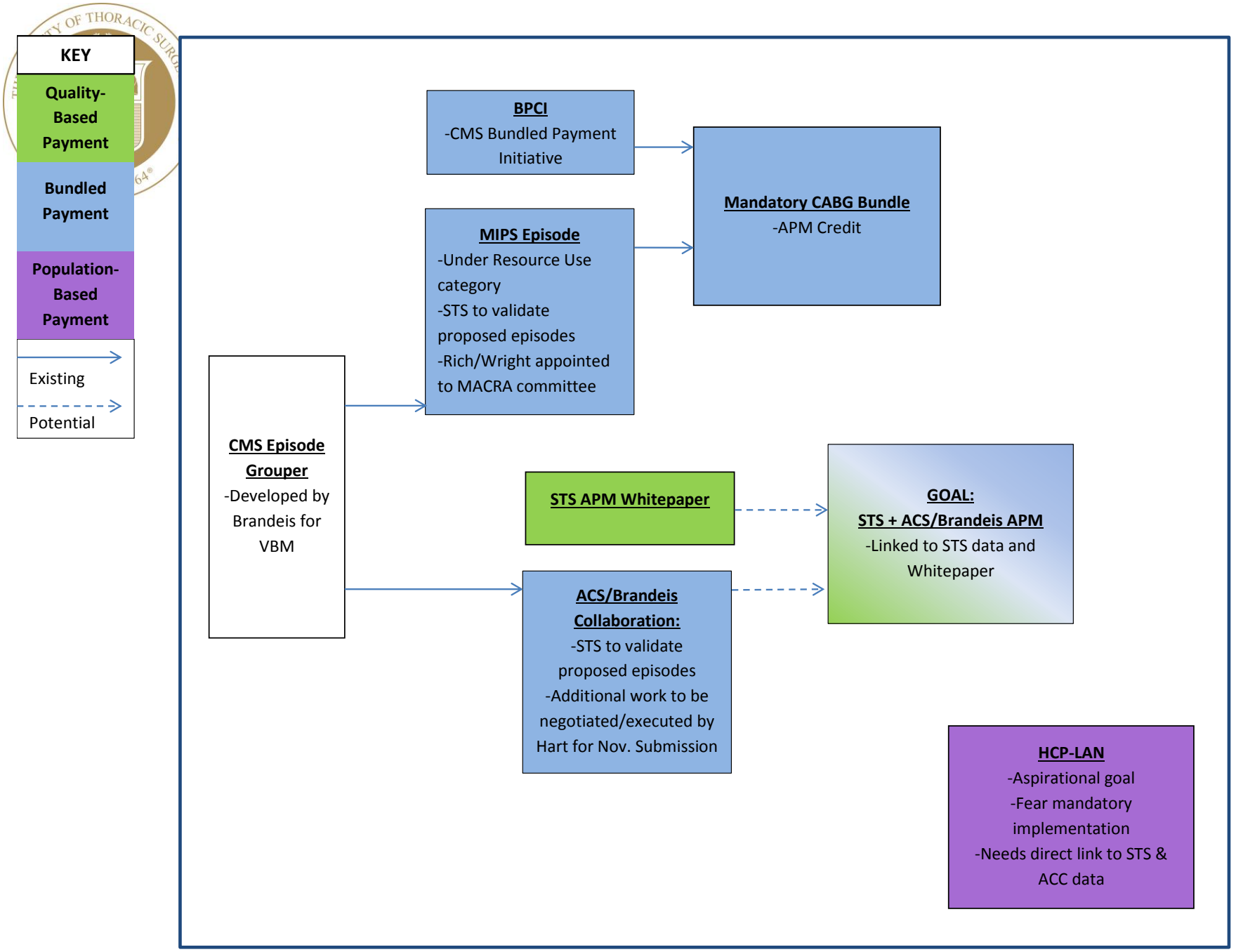
Questions?

The Society of Thoracic Surgeons

MACRA Briefing

Where Does Industry Fit?

- What risk models could Providers (Hospitals/Physicians) and Medtronic develop?
- How would up-side and down-side risk or results be evaluated?
- Who would evaluate and track such results? Medtronic vs Hospital Systems?
- How would such relationships fit under existing Regulatory criteria? What are such legal restrictions or opportunities? Could they be modified under the modifications of the Bill?


KEY
Quality-Based Payment
Bundled Payment
Population-Based Payment
Existing
Potential
BPCI
-CMS Bundled Payment Initiative
Mandatory CABG Bundle
-APM Credit
MIPS Episode
-Under Resource Use category
-STS to validate proposed episodes
-Rich/Wright appointed to MACRA committee
CMS Episode Grouper
-Developed by Brandeis for VBM
STS APM Whitepaper
GOAL:
STS + ACS/Brandeis APM
-Linked to STS data and Whitepaper
ACS/Brandeis Collaboration:
-STS to validate proposed episodes
-Additional work to be negotiated/executed by Hart for Nov. Submission
HCP-LAN
-Aspirational goal
-Fear mandatory implementation
-Needs direct link to STS & ACC data