CHA MEMBER FORUM: CANCELLATION OF EPMs, REVISIONS TO CJR, AND DEVELOPMENT OF APMs

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Download the presentation: https://www.calhospital.org/resource/slides-cha-member-forum-cancellation-epms-and-cjr-revisions

Today's Speakers

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Overview and Agenda

- Review CMS proposed rule: Cancellation of EPM, Cardiac Rehab and SHFFT
- Review CHA draft comments – due October 16
  - Draft letter available week of 10/9
- APMs and Strategic Considerations for Hospitals
- CMMI – Request for information (RFI) regarding future development of Alternative Payment Models (APMs(
  - Comments due November 20
  - CHA interested in ongoing member feedback

EPM Proposed Rule – Overview

- Cancels the mandatory Cardiac (CABG and AMI) episode payment model for ALL markets
- Cancels the mandatory Cardiac Rehab Model for ALL markets
- Cancels the expansion of CJR to SHFFT episodes for ALL markets

EPM Proposed Rule – Overview

- CMS proposes to continue mandatory participation for CJR participants in 34 of 67 MSAs
  - Los Angeles- Long Beach- Anaheim remain **mandatory** CJR MSAs
- CMS proposes to make 33 MSAs voluntary
  - Modesto and San Francisco-Oakland-Hayward MSAs proposed to be **voluntary**
- CMS proposes to allow for voluntary opt-in for those low volume, rural providers located in mandatory MSAs

Low Volume and Rural Definitions

- Low volume: Providers with fewer than 20 CJR episodes in total across 3 years of historical data
- Rural hospital means an IPPS hospital that meets one of the following definitions:

1) Is located in a rural area as defined under §412.64 of this chapter.
2) Is located in a rural census tract defined under §412.103(a)(1) of this chapter.
3) Has reclassified as a rural hospital under §412.103 of this chapter.

b) Episode quality-adjusted target price. (1) CMS calculates quality-adjusted target prices based on a blend of each participant hospital's hospital-specific and regional episode expenditures. The region corresponds to the U.S. Census Division associated with the primary address of the CCN of the participant hospital and the regional component is based on all hospitals in said region, except as follows. In cases where an MSA selected for participation in CJR spans more than one U.S. Census Division, the entire MSA will be grouped into the U.S. Census Division where the largest city by population in the MSA is located for quality-adjusted target price and reconciliation calculations.

Low Volume

TABLE 3—LOW-VOLUME HOSPITALS LOCATED IN THE MANDATORY MSAS ELIGIBLE TO OPT-IN DURING VOLUNTARY ELECTION PERIOD

CCN	Hospital name	MSA	MSA Title
010034	Community Hospital, Inc	33860	Montgomery, AL.
010062	Wiregrass Medical Center	20020	Dothan, AL.
010095	Hale County Hospital	46220	Tuscaloosa, AL.
010097	Elmore Community Hospital	33860	Montgomery, AL.
010108	Prattville Baptist Hospital	33860	Montgomery, AL.
010109	Pickens County Medical Center	46220	Tuscaloosa, AL.
010149	Baptist Medical Center East	33860	Montgomery, AL.
040132	Leo N. Levi National Arthritis Hospital	26300	Hot Springs, AR.
050040	LAC-Olive View-UCLA Medical Center	31080	Los Angeles-Long Beach-Anaheim, CA.
050091	Community Hospital of Huntington Park	31080	Los Angeles-Long Beach-Anaheim, CA.
050137	Kaiser Foundation Hospital-Panorama City	31080	Los Angeles-Long Beach-Anaheim, CA.
050138	Kaiser Foundation Hospital-Los Angeles	31080	Los Angeles-Long Beach-Anaheim, CA.
050139	Kaiser Foundation Hospital-Downey	31080	Los Angeles-Long Beach-Anaheim, CA.
050158	Encino Hospital Medical Center	31080	Los Angeles-Long Beach-Anaheim, CA.
050205	Glendora Community Hospital	31080	Los Angeles-Long Beach-Anaheim, CA.
050373	LAC+USC Medical Center	31080	Los Angeles-Long Beach-Anaheim, CA.
050378	Pacifica Hospital of the Valley	31080	Los Angeles-Long Beach-Anaheim, CA.
050411	Kaiser Foundation Hospital-South Bay	31080	Los Angeles-Long Beach-Anaheim, CA.
050468	Memorial Hospital of Gardena	31080	Los Angeles-Long Beach-Anaheim, CA.
050543	College Hospital Costa Mesa	31080	Los Angeles-Long Beach-Anaheim, CA.
050548	Fairview Developmental Center	31080	Los Angeles-Long Beach-Anaheim, CA.
050552	Motion Picture & Television Hospital	31080	Los Angeles-Long Beach-Anaheim, CA.
050561	Kaiser Foundation Hospital-West Los Angeles	31080	Los Angeles-Long Beach-Anaheim, CA.
050609	Kaiser Foundation Hospital-Orange County-Anaheim	31080	Los Angeles-Long Beach-Anaheim, CA.
050641	East Los Angeles Doctors Hospital	31080	Los Angeles-Long Beach-Anaheim, CA.
050677	Kaiser Foundation Hospital-Woodland Hills	31080	Los Angeles-Long Beach-Anaheim, CA.
050723	Kaiser Foundation Hospital-Baldwin Park	31080	Los Angeles-Long Beach-Anaheim, CA.
050738	Greater El Monte Community Hospital	31080	Los Angeles-Long Beach-Anaheim, CA.
050744	Anaheim Global Medical Center	31080	Los Angeles-Long Beach-Anaheim, CA.
050747	South Coast Global Medical Center	31080	Los Angeles-Long Beach-Anaheim, CA.
050751	Miracle Mile Medical Center	31080	Los Angeles-Long Beach-Anaheim, CA.

TABLE 3—LOW-VOLUME HOSPITALS LOCATED IN THE MANDATORY MSAS ELIGIBLE TO OPT-IN DURING VOLUNTARY ELECTION PERIOD—Continued

CCN	Hospital name	MSA	MSA Title
050771	Coast Plaza Hospital	31080	Los Angeles-Long Beach-Anaheim, CA.
050776	College Medical Center	31080	Los Angeles-Long Beach-Anaheim, CA.
050779	Martin Luther King Jr. Community Hospital	31080	Los Angeles-Long Beach-Anaheim, CA.
050780	Foothill Medical Center	31080	Los Angeles-Long Beach-Anaheim, CA.
050782	Casa Colina Hospital	31080	Los Angeles-Long Beach-Anaheim, CA.
070038	Connecticut Hospice Inc	35300	New Haven-Milford, CT.
070039	Masonic Home and Hospital	35300	New Haven-Milford, CT.

One Time Opt-in for Voluntary Participation

- CMS proposes a one time voluntary opt-in for CJR hospitals for January 31, 2018
  - CMS to provide a form for easy submission
- CMS proposal in OPPS rule for TKA removal from IPO will not be final until ~November 1
  - This uncertainty presents a number of challenges for providers as they consider their decision to opt-in or not

Other Technical Changes

- Codes for telehealth
- Clinician engagement lists for qualification under the APM track
- Implications for reconciliation in performance year 1 on quality score composite change

CHA Draft Comments

- Support cancellation of EPMs (CABG, AMI and SHFFT)
  - Urge CMMI to issue new voluntary programs ASAP – including cardiac rehab
  - **Ask CMS to consider making all markets voluntary with multiple opt-in periods**
- Support rural and low volume opt-in; call into question the inadequacy of low volume definition but do not identify a specific threshold for volume
- Request multiple opt-in periods in light of TKA decision pending and more APMs coming online
- Do not apply new quality measure methodology until year 2 performance

CHA Draft Comments

- Restate concerns with removal of TKA procedures as proposed in OPPS
  - CHA Opposed removal of TKA from IPO
- Other considerations outside the scope of the rule:
  - Capping target price at 2/3 rather than moving to 100% regional pricing

Questions or Comments

Alternative Payment Models and Strategic Considerations for Hospitals

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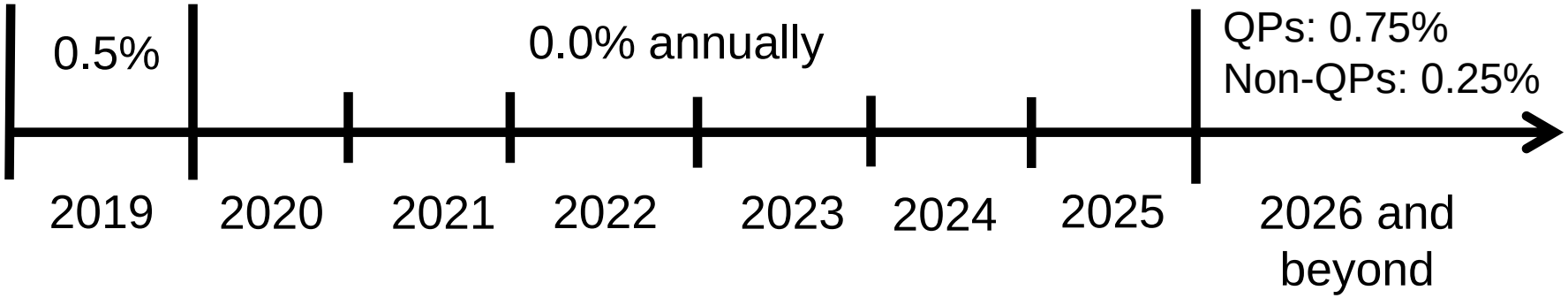
Advanced APM Payment Incentives

Mandated PFS Update



Advanced APM: Bonus of 5% of Medicare part B payments annually for Qualifying APM Professionals (QPs) 2019-2024

5% APM bonus generally applies to participation in an APM performance period 2 years prior to payment

Advanced APM Criteria

- To be an **Advanced APM**, an APM must meet the following three criteria:
  - Require participants to use certified electronic health record technology (CEHRT)
  - Provide payment for covered professional services based on quality measures comparable to those used in the Merit-based Incentive Payment System (MIPS) quality performance category
  - Require participating APM Entities to bear a more than nominal amount of financial risk.

Current Advanced APMs

2017 Advanced APMs	2018 Advanced APMs
• MSSP Track 2 • MSSP Track 3 • Next Generation ACO • Comprehensive ESRD Care Model • Oncology Care Model (Two-sided track) • CPC+	• MSSP Track 1+ • MSSP Track 2 • MSSP Track 3 • Next Generation ACO • Comprehensive ESRD Care Model • Oncology Care Model (Two-sided track) • CPC+ • **Comprehensive Care for Joint Replacement (CJR) Track 1 (CEHRT)**

CJR Track 1 - CEHRT

- Track 1 CJR hospitals must:
  - Attest to their use of Certified EHR Technology
  - Periodically provide “Clinician Financial Arrangement” lists to CMS of CJR Collaborators
    - CJR Collaborators must be engaged in a contractual sharing arrangement with the hospital to support the quality and/or cost goals of the CJR model

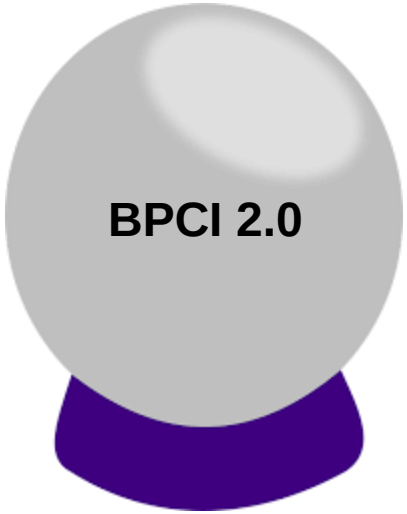
Note: Requirements finalized in the EPM final rule at 42 CFR § 510.120, delayed until Jan. 1, 2018

CJR Track 1 Proposal

- CMS proposes to expand opportunities for clinicians not linked to CJR model financially to qualify for Advanced APM incentives
- "Clinician Engagement List" would capture all affiliated clinicians who have contractual agreement to support the hospital's quality or cost goals under the CJR model
  - Hospitals are required to collect information on affiliated clinicians and submit list to CMS
  - Hospitals would also be required to attest if no individuals meet this criteria

Current BPCI Models

APM	Use of CEHRT	Quality Measures	Financial Risk
BPCI Model 2	X	X	✓
BPCI Model 3	X	X	✓
BPCI Model 4	X	X	✓



- BPCI 2.0 expected to include CEHRT and Quality criteria to meet Advanced APM requirements

Timelines for Consideration

CJR Voluntary/Mandatory Qualified APM for MACRA	Final rule – could be as late as mid-December	Jan 31, 2018 deadline to opt in
BPCI 1.0 Voluntary – **NOT A Qualified APM**	Most end September 30, 2018	BPCI episodes take precedent over CJR episodes
BPCI 2.0 Expected to be a Qualified APM	Announcement Eminent	Expected Start date October 1, 2018
Pending additional Qualified APMs	RFI - comments due November 20	Next steps unclear

Strategic Considerations for Hospitals

- Timing of election to stay in CJR may have consequences for clinicians looking for support on MIPS reporting or APM participation
- What mechanisms do you have in place to keep clinicians aligned in CJR if BPCI 2.0 comes out and is more attractive to them?
- Have you made the investment required for successful APM participation? If so, does this make sense strategically for you to align with your physicians?
- What other issues are coming up that may be of concern?

Questions

CMMI Request for Information: Development of Alternative Payment Models

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RFI Guiding Principles

- Choice and competition in the market
- Provider choice and incentives
- Patient centered care
- Benefit design and price transparency
- Transparent model design and evaluation
- Small scale testing

Administration Focus Areas - RFI

- Increased participation in Advanced APMs
- Consumer-Directed and Market-Based Innovations
- Physician Specialty Models
- Prescription Drug Models
- Medicare Advantage Innovation Models
- State-Based and Local Innovation, including Medicaid Innovation Models
- Mental and Behavioral Health Models
- Program Integrity Models

CHA Draft APM Guiding Principles

- Remove legal and regulatory barriers to clinical integration under models, such as Stark Law and anti-kickback statute
- Support hospital-led and initiated APMs
- Support voluntary participation for all APMs
- Include upfront investment costs in financial risk calculations
- APM quality measures should include robust use of risk adjustment – including for sociodemographic status where appropriate

Discussion Questions

- Despite limited information provided, are there models that present more opportunities than others?
- Should CHA advise CMS to prioritize development of certain models?
- What components of these models are most attractive to members?
- What hasn't CMMI proposed in the RFI that is worthy of consideration?
- Comments due November 20

THANK YOU

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