Practice made perfect:
Transforming Care in a Value Environment

ACC Podcast
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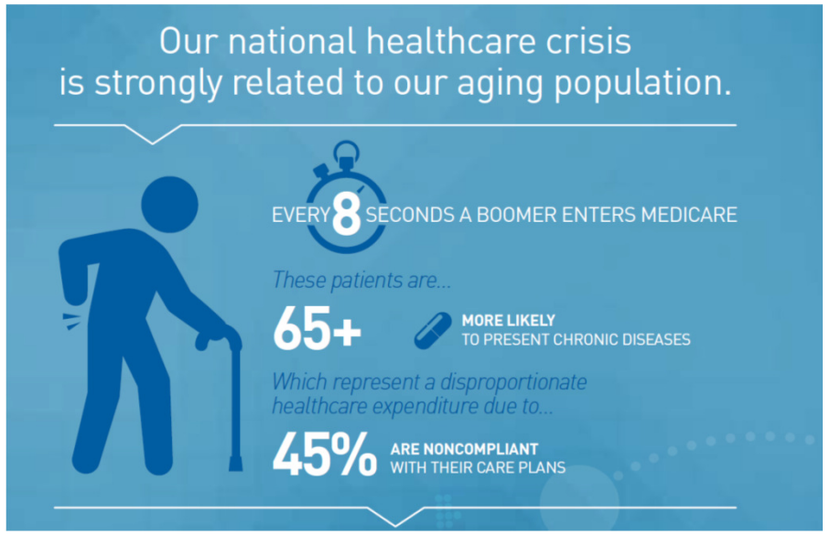
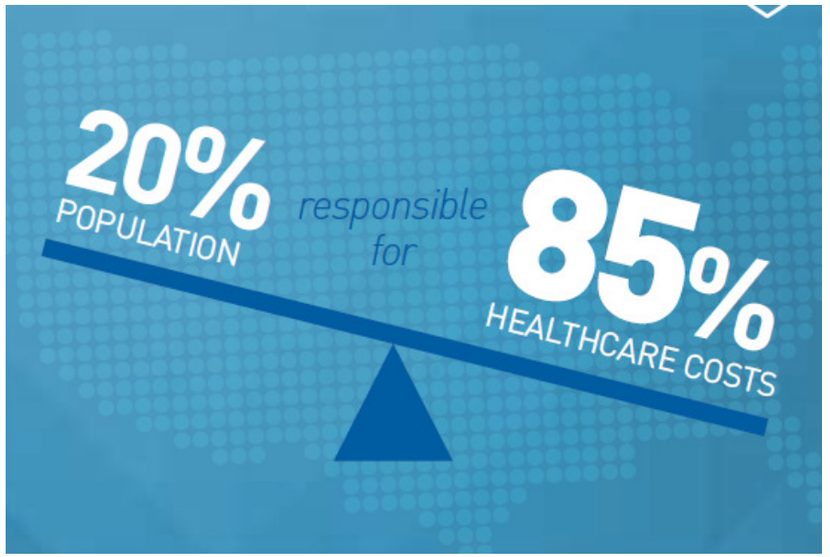
Agenda

- Environmental trends
- Movement to Value
  - Hospital
  - Physician
- MACRA/QPP/Episodes/QRUR/s-QRUR/FTE
- Where is this data?
- How do we use this data?

Those Boomers…….

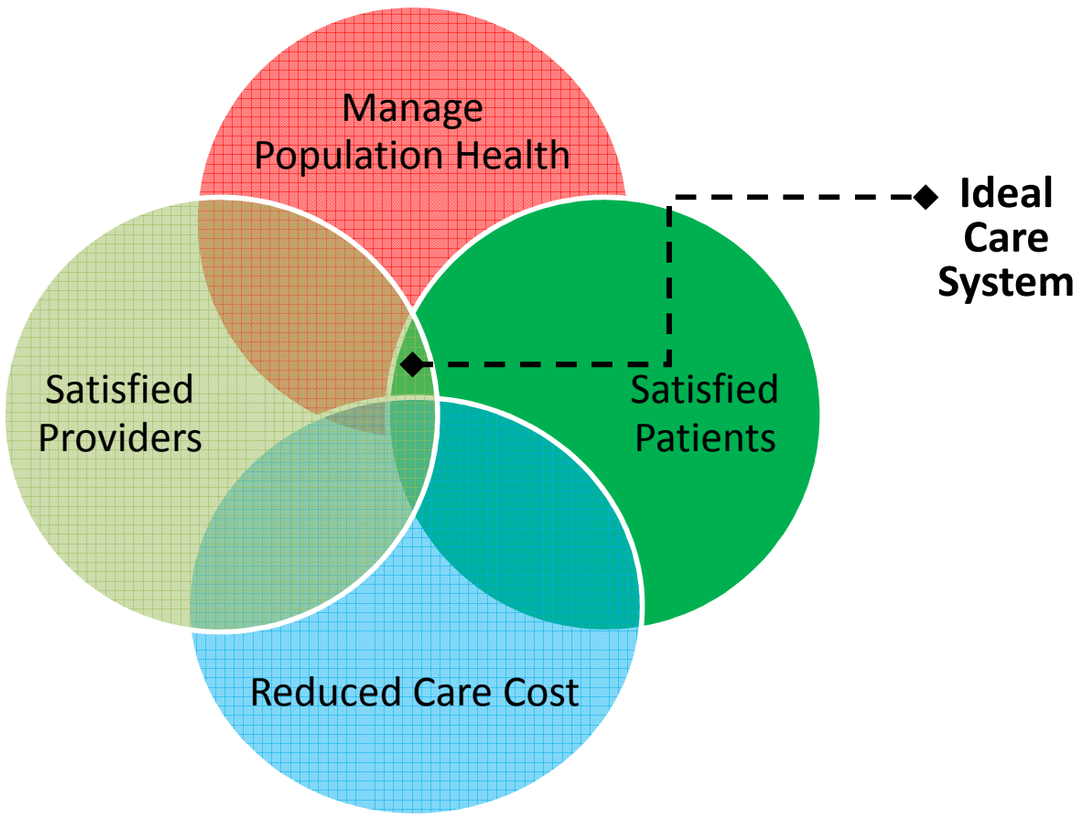




The convergence of quality and finance

- If you are physicians and providers
- Your goal is to provide expert cardiovascular care to your patients
- If you are an administrator – your goal is to try to understand all this
- However……..
- Providers YOU are responsible for your data and while your admin team will try to help……you need to own your data!

Quadruple Aim

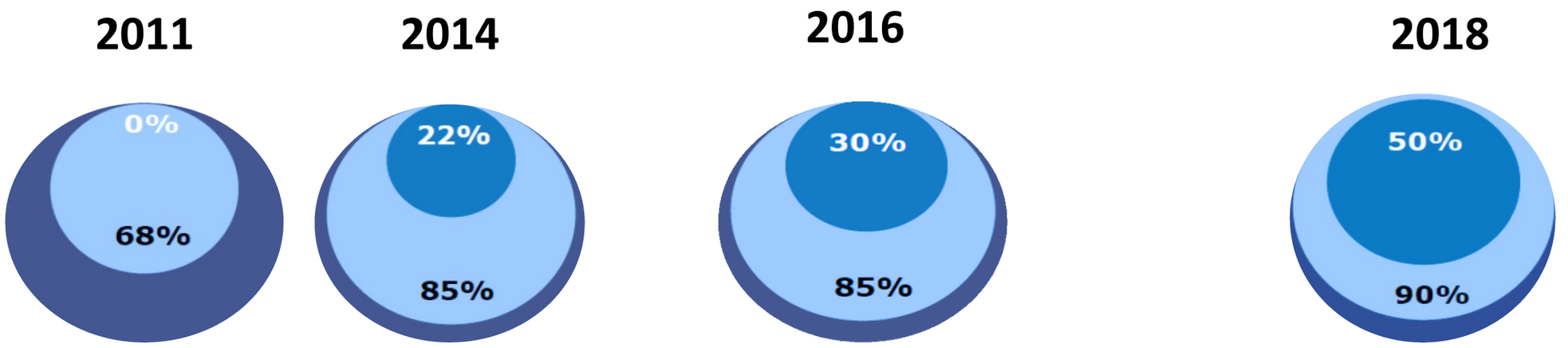


Where Have We Been?

How Do We Get Here?

Historical Performance

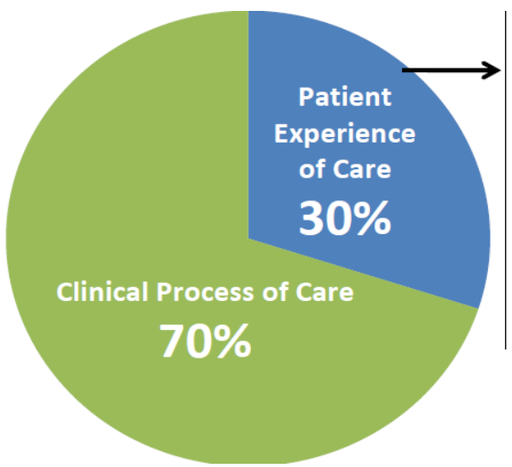
Goal



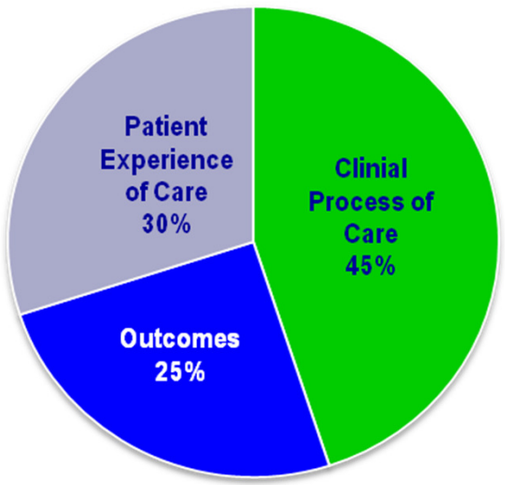
Alternative payment models (categories 3-4)
FFS linked to quality (categories 2-4)
All Medicare FFS (categories 1-4)

CMS Value Based Purchasing

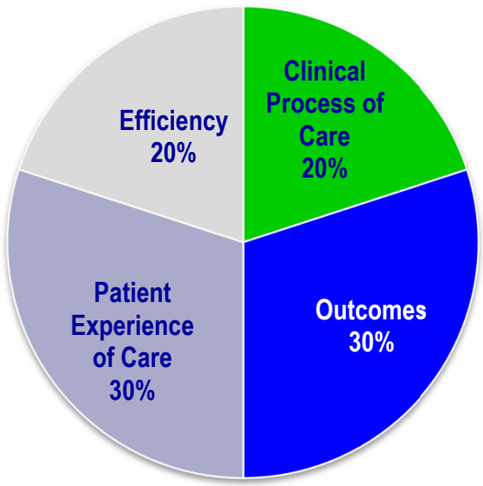
FY 2013



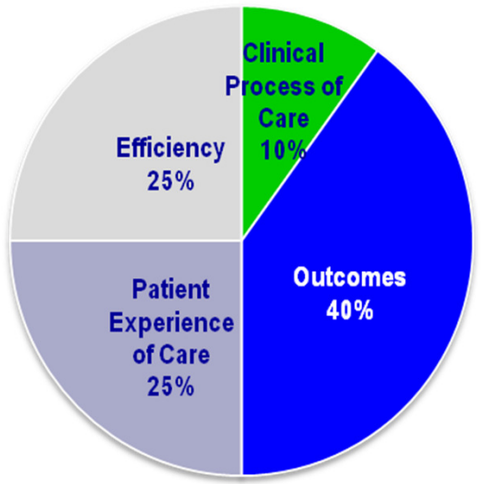
FY 2014



FY 2015

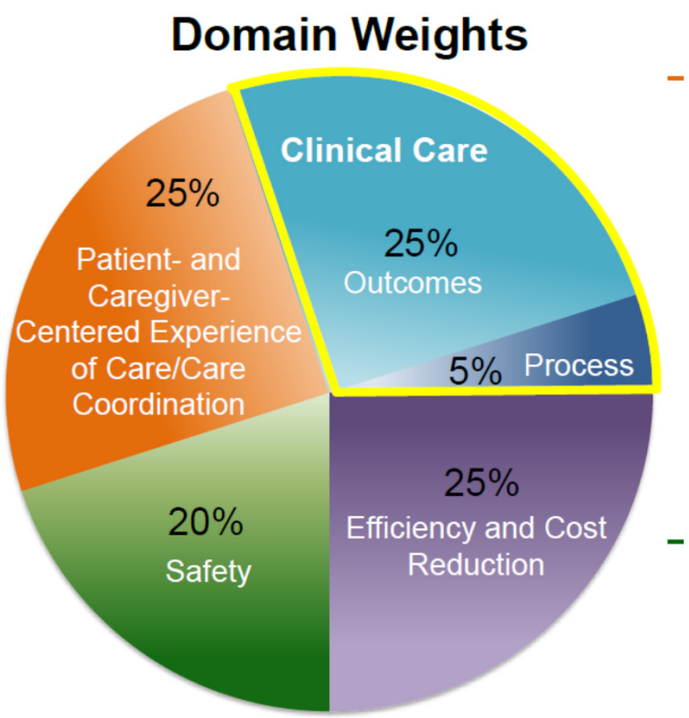


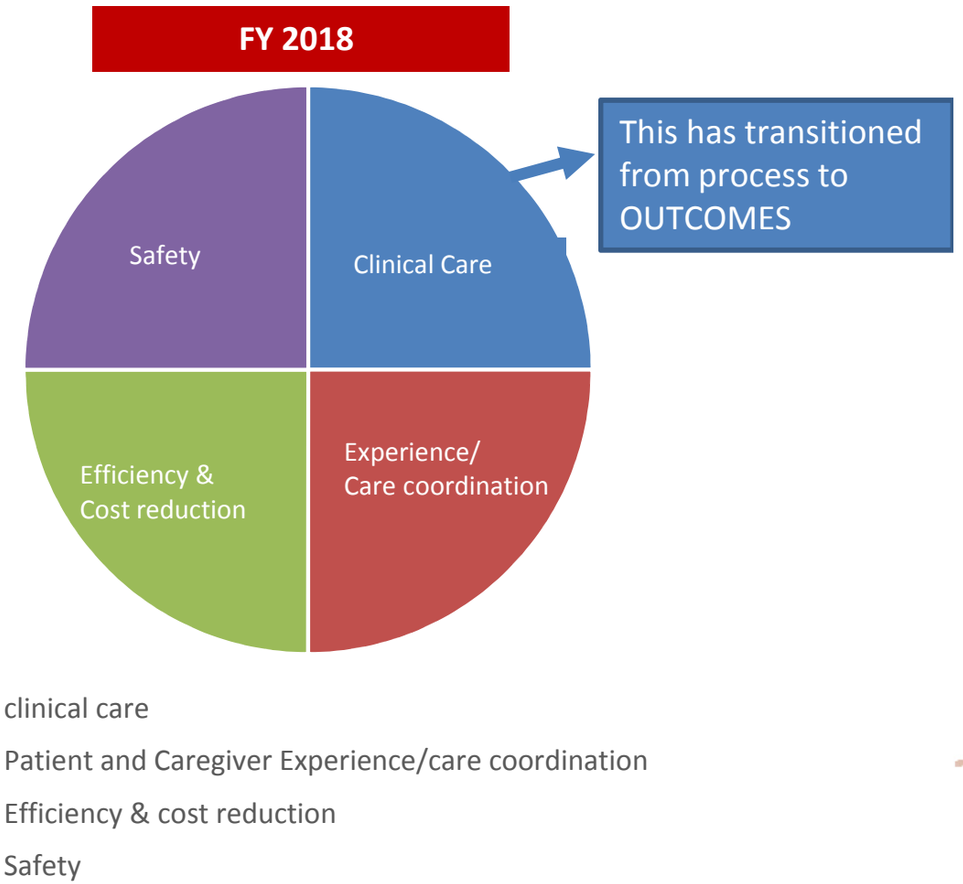
FY 2016



CMS is rapidly changing the weighting of each Value Based Purchasing Domain as well as the content within each domain making systematic and proactive performance improvement more difficult.

And here we are…..FY ‘17 and FY ‘18





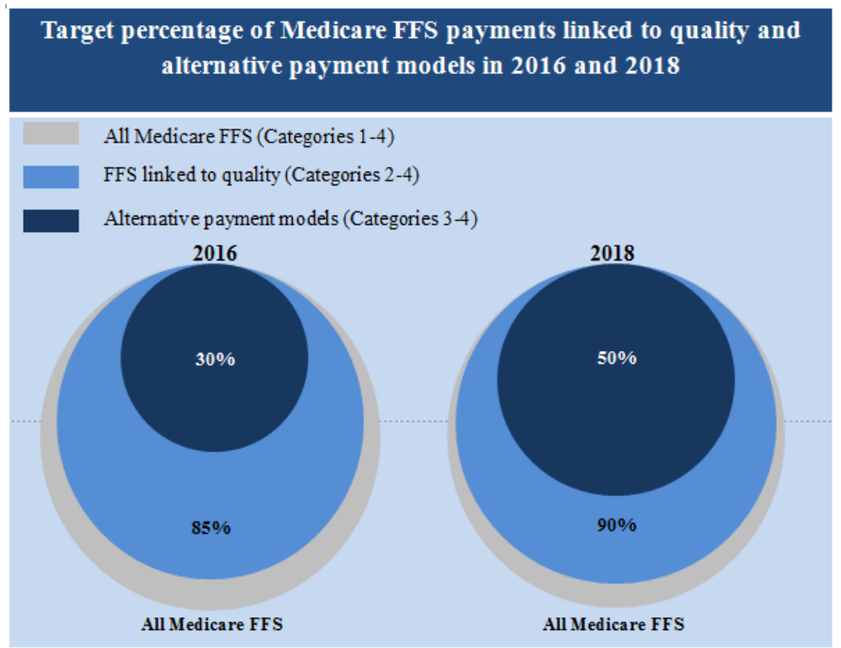
Value Agenda: Physician

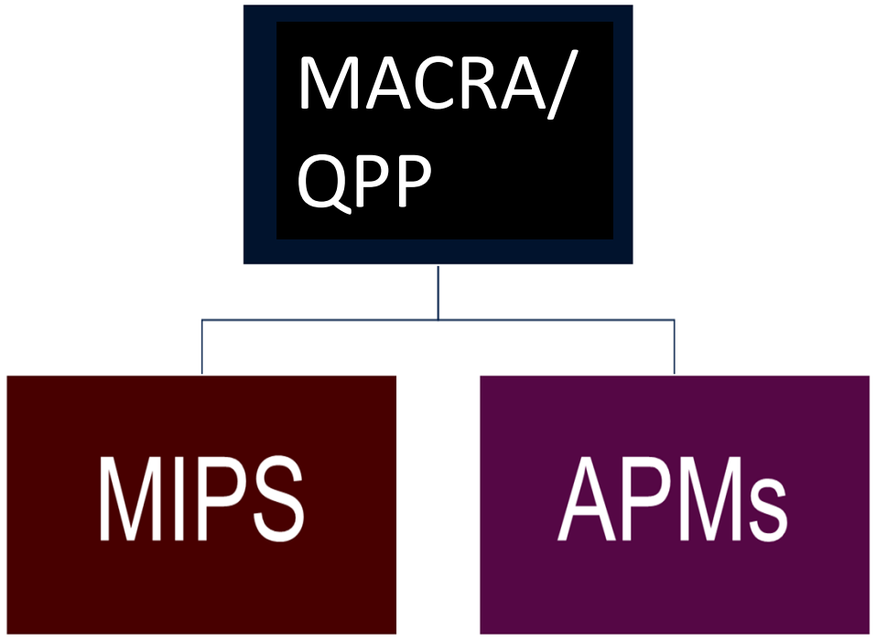
Where were we:

- Meaningful Use
- PQRS
- Value Modifier
  - QRUR
  - S-QRUR
  - Physician Compare

- 2017: Hello QPP
  - MIPs – Quality, Cost, ACI, IA
  - APM – Alternate Payment Models

HHS mandate followed by MACRA/QPP





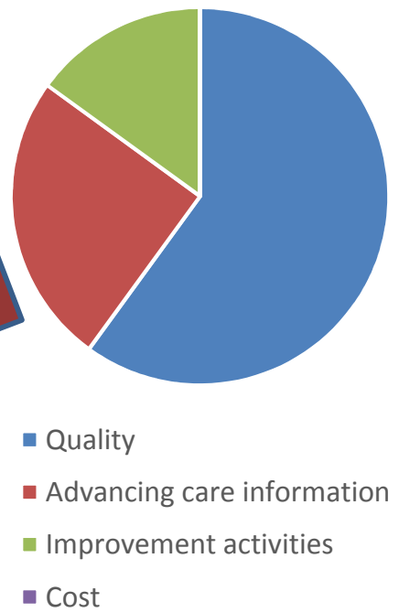
The Basics of MACRA/QPP

- **M**edicare **A**ccess and **C**HIP **R**eauthorization **A**ct
- Name change 2017: QPP – Quality Payment Programs
- Eliminated SGR
- Effective 1/1/19
- MACRA/QPP
  - APM: base year will be 2017
    - There are only a few “qualifying APM’s
  - MIPS: base year will be 2017

MIPS: 100 points – 4 categories

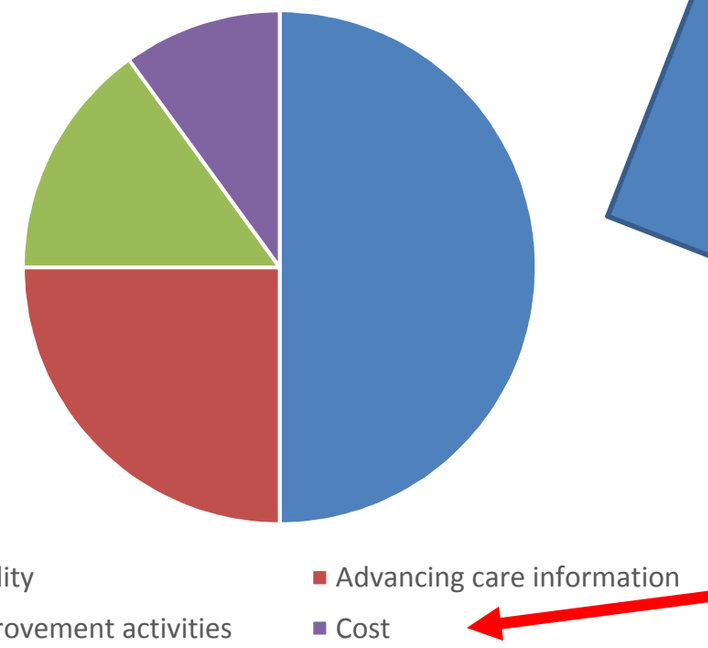
- 2017 data for 2019

100 points:
60 for quality
25 for ACI
15 for IA
0 for cost



- 2018 data for 2019

100Points:
50 for quality
25 for ACI/PI
15 for IA
10 for cost



QRUR and MIPS

- QRUR serves as a roadmap for MIPS
- It identifies 2 of the 3 cost components
  - The third is now available - episodes
- Gives you your quality score card
- Identifies risk scoring opportunities

QRUR: Quality resource & utilization report

- Annually distributed to EVERY provider's TIN
  - Includes physicians and APP's
- Is based on your TIN – aka who you bill through
  - If you have multiple TIN's – be careful
- Has both cost and quality for providers

Components of QRUR

- Quality: PQRS measures +
  - Three outcome measures – calculated by CMS based on claims for preventable hospital admissions
    - Acute prevention Quality indicators – dehydration, UTI, pneumonia
    - Composite of chronic prevention - CHF, COPD, diabetes
    - All cause hospital readmission (200 cases)
- Cost:
  - 2018 *per capita +*
  - MSPB: Remember 3 days pre "event" and 30 days post
    - MSPB will be used as another domain for cost
      - Risk adjusted and GPCI removed
      - Specialty adjusted
  - 2019 will include 8 episode – 2020 will include 10 episodes

2016 QRUR

Released 9/17

It has your Quality scores

PERFORMANCE PERIOD: 01/01/2016 – 12/31/2016

ABOUT THIS REPORT FROM MEDICARE

The 2016 Annual Quality and Resource Use Report (QRUR) shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed in calendar year 2016 on the quality and cost measures used to calculate the Value-Based Payment Modifier (Value Modifier) for 2018.

In 2018, the Value Modifier will apply to all physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists (clinicians subject to the Value Modifier) who bill under the Medicare Physician Fee Schedule.

The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at the discretion of the Centers for Medicare & Medicaid Services (CMS), including, but not limited to, circumstances in which an error is discovered.

Please note that payment adjustments under the 2018 Value Modifier are based on a proposal that was included in the 2018 Medicare Physician Fee Schedule Proposed Rule (82 FR 34124) and is subject to change. Information on the Proposed Rule can be found at https://federalregister.gov/d/2017-14639.

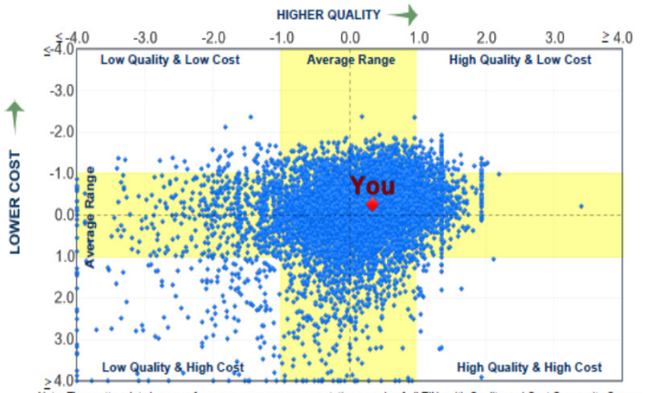
YOUR TIN'S 2018 VALUE MODIFIER

Average Quality, Average Cost = Neutral Adjustment (0.0%)

Your TIN's overall performance was determined to be average on quality measures and average on cost measures.

This means that the Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for clinicians subject to the Value Modifier billing under your TIN in 2018 will result in a neutral adjustment, meaning no adjustment (0.0%).

The scatter plot below shows how your TIN ("You" diamond) compares to a representative sample of other TINs on the Quality and Cost Composite scores used to calculate the 2018 Value Modifier.



Note: The scatter plot shows performance among a representative sample of all TINs with Quality and Cost Composite Scores reflecting standard deviations from the mean for each Composite Score.

You need an EDIM account to access

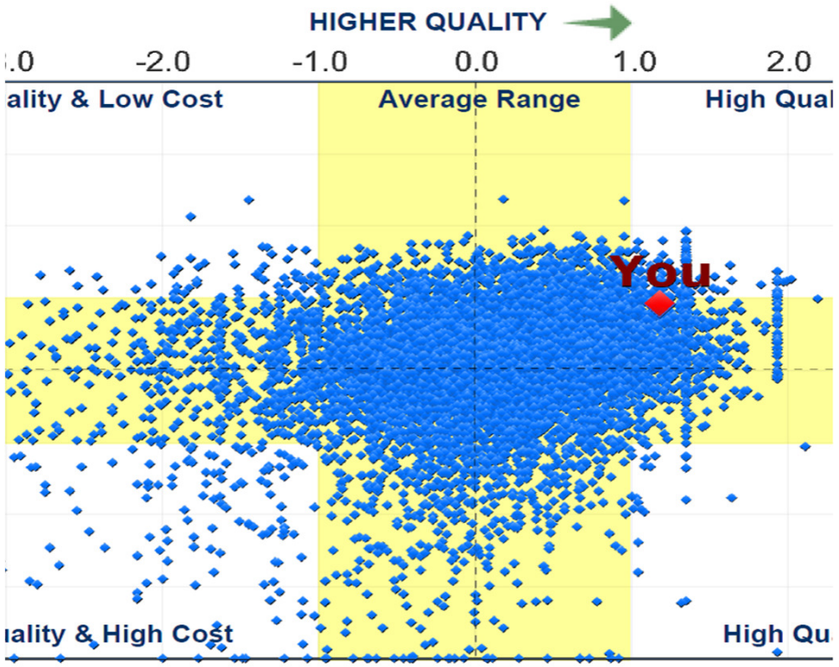
Did you get a penalty??

2016 QRUR

e was determined to be high on quality measures and averag

difier applied to payments for items and services under the M
t to the Value Modifier billing under your TIN in 2018 will resu
ment factor.

how your TIN ("You" diamond) compares to a representative
cores used to calculate the 2018 Value Modifier.



QRUR……risk score

How does the high-risk bonus adjustment apply to your TIN?

TINs that qualify for an upward adjustment under quality-tiering will receive an additional upward adjustment to their 2017 Value Modifier equal to one (1.0) times the adjustment factor, if they served a disproportionate share of high-risk beneficiaries in 2015. The average risk for all beneficiaries attributed to your TIN is at the 78th percentile of beneficiaries nationwide.

Medicare determined your TIN's eligibility for the high-risk bonus adjustment based on whether your TIN met (✓) or did not meet (✗) both of the following criteria in 2015:

- ✗ Had strong quality and cost performance
- ✓ Average beneficiary's risk is at or above the 75th percentile of beneficiaries nationwide

Your TIN will not receive the high-risk bonus adjustment to the 2017 Value Modifier because your TIN did not meet these criteria.

How does the high-risk bonus adjustment apply to your TIN?

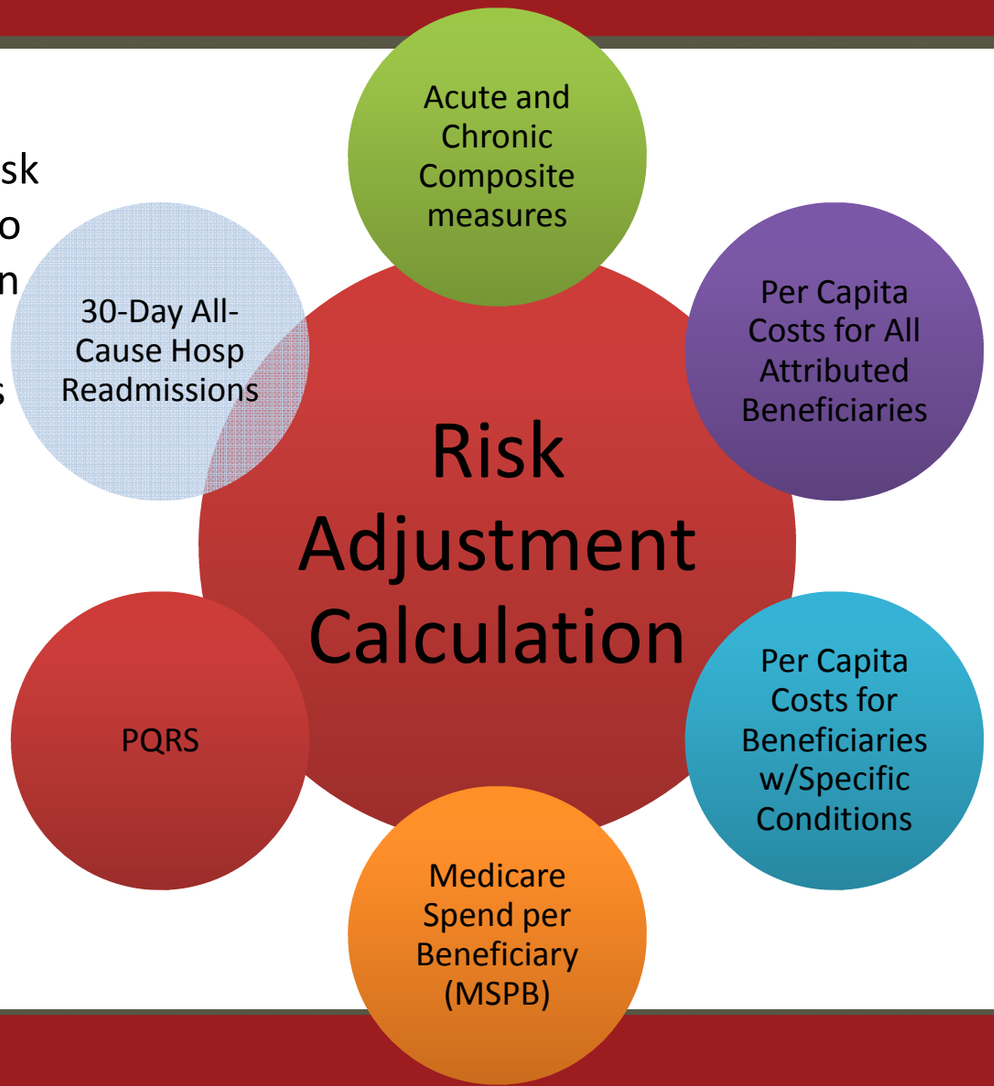
TINs that qualify for an upward adjustment under quality-tiering will receive an additional upward adjustment to their 2018 Value Modifier equal to one (1.0) times the adjustment factor, if they served a disproportionate share of high-risk beneficiaries in 2016. The average risk for all beneficiaries attributed to your TIN is at the 84th percentile of beneficiaries nationwide.

Medicare determined your TIN's eligibility for the high-risk bonus adjustment based on whether your TIN met (✓) or did not meet (✗) both of the following criteria in 2016:

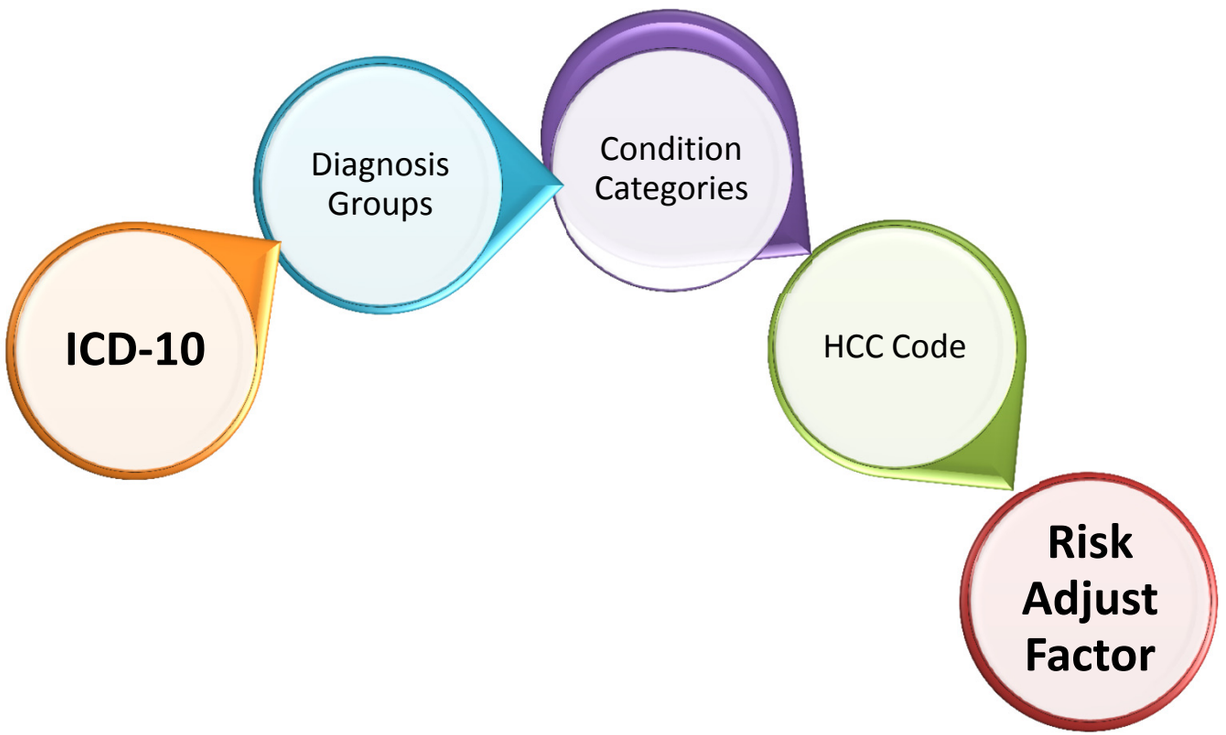
- ✗ Had strong quality and cost performance
- ✓ Average beneficiary's risk is at or above the 75th percentile of beneficiaries nationwide

Is documentation really important

Measures are risk adjusted prior to their inclusion in the QRURs and VM calculations



Risk adjustment methodologies vary for each


ICD-10
Diagnosis Groups
Condition Categories
HCC Code
Risk Adjust Factor

Risk Comparison

Patient A

- Medicare, Age 70
- CAD
- HTN

Patient B

- Medicare, Age 70
- CAD
- S/P CABG
- Diabetes
- HTN
- ESRD
- Acute on chronic diastolic heart failure

Does it really matter……

HCC Financial Differences in Coding Specificity

No Conditions Coded (Demographics Only)		Some Conditions Coded (Claims Data Only)		All Conditions Coded (Chart Review by Certified Coder)	
76 year-old female	.468	76 year-old female	.468	76 year-old female	.468
Medicaid Eligible	.177	Medicaid Eligible	.177	Medicaid Eligible	.177
DM Not Coded		DM (no manifestations)	.118	DM with Vascular Manifestations	.368
Vascular Disease not coded		Vascular Disease without complication	.299	Vascular Disease with complication	.41
CHF not coded		CHF not coded		CHF coded	.368
No interaction		No interaction		+ Disease Interaction bonus RAF (DM + CHF)	.182
Patient Total RAF	.645	Patient Total RAF	1.062	Patient Total RAF	1.973
PMPM Payment for Care	$452	PMPM Payment for Care	$743	PMPM Payment for Care	$1,381
Yearly Reserve for Care	$ 5,418	Yearly Reserve for Care	$8,921	Yearly Reserve for Care	$16,573

How to improve your scores

- Ensure you are billing the full list of diagnosis
- Develop a practice-based clinical documentation improvement program
- Begin to analyze QRUR and Supplemental report data
- Compare claim data against actual patient records
- Develop an internal compliance plan, implement internal and external chart reviews
- Feedback and education to providers

HCC – Hierarchical Condition Category 101

The Least You Need To Know

Model Is Here To Stay In One Form Or Another

- The HCC model has been the basis for reimbursement to MAO plans since 2004.
- Due to it's proven success in predicting resource use it is now being used to determine much more and by more payors.

Goes To A Blank Slate Every Calendar Year

- The CMS model is accumulative – a patient can have more than one HCC category assigned to them. Some categories override others and there is a hierarchy of categories.
- **The HCC must be captured using claims data from a face to face encounter every 12 months.**

Subject To Data Validation Sampling

- The HCC must be documented and supported in the medical record and this can be subject to a "data validation" review
- The plan must submit the "one best medical record" that supports the patient's HCC scoring if identified for validation.

The HCC & RAF Connection 79 to 3,000

- Patients with multiple HCCs in a single category will be scored at the highest level
- *Additional risk is scored when certain conditions coexist
- When multiple conditions are present in the same patient a higher score will be used . i.e. CHF & COPD or CHF & CRF

MIPS: 4 categories

- Quality
- If in a non-qualifying ACO you will be a MIPS/ACO participant
- Quality scores in your ACO will follow your ACO
  - Probably population health measures
- If you are not in an ACO:
  - You will need 12 months of data in 2018
  - The measures are for ALL payors
  - Worth 50% of your MIPS score

How Do I Understand My Score

- Above all… benchmarking counts!

Measure_Name	Submission _Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Claims	95.60 - 97.85	97.86 - 99.25	99.26 - 99.99	--	--	--	--	100.00
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	EHR	72.59 - 81.59	81.60 - 86.68	86.69 - 90.15	90.16 - 92.64	92.65 - 94.67	94.68 - 96.58	96.59 - 98.51	>= 98.52
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Registry/QCDR	76.67 - 85.53	85.54 - 89.87	89.88 - 92.85	92.86 - 95.14	95.15 - 97.21	97.22 - 99.10	99.11 - 99.99	100.00

Measure_Name	Submission _Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Controlling High Blood Pressure	Claims	57.69 - 63.44	63.45 - 68.28	68.29 - 72.78	72.79 - 77.06	77.07 - 81.47	81.48 - 86.75	86.76 - 93.42	>= 93.43
Controlling High Blood Pressure	EHR	50.00 - 55.39	55.40 - 59.72	59.73 - 63.59	63.60 - 67.38	67.39 - 71.00	71.01 - 75.33	75.34 - 80.89	>= 80.90
Controlling High Blood Pressure	Registry/QCDR	51.00 - 58.20	58.21 - 63.56	63.57 - 68.27	68.28 - 72.40	72.41 - 76.69	76.70 - 82.75	82.76 - 91.06	>= 91.07

Measure_Name	Submission _Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Hypertension: Improvement in Blood Pressure	EHR	6.82 - 9.31	9.32 - 11.70	11.71 - 14.40	14.41 - 17.39	17.40 - 21.44	21.45 - 27.61	27.62 - 39.04	>= 39.05
Hypertension: Improvement in Blood Pressure	Registry/QCDR	2.39 - 2.93	2.94 - 3.46	3.47 - 3.92	3.93 - 4.71	4.72 - 5.53	5.54 - 6.74	6.75 - 9.99	>= 10.00

MIPS 2nd category: Advancing Care Information

- Replaces Meaningful Use (MU)
- Changed its name AGAIN – 2018 it is now: Promoting Interoperability Programs
- Accounts for 25% of your 2017 & 2018 MIPS score
  - Base score worth 50%
  - Performance score worth up to 90%
  - Bonus score worth up to 15%
- Total points possible: 155
  - 100 or more points = full 25 points
- For 2017 & 2018 there are 2 measure sets – depends on your EHR edition
- As of June, 2018 you need to move to the “new” 2015 platform

Challenges

- Remembering it is not about thresholds anymore – but N/D's
- Does your EHR interpret the rules the same way you do
- Are the denominator definitions consistent with practice
- Email addresses for 85 yr old patients
- Continuity of care documents (CCD's) electronically sent to referring providers
- Getting your EHR vendors to meet requirements timely
- Upgrading to 2015 version…….reprieve til next yr ☺

MIPS: 3rd category = Cost

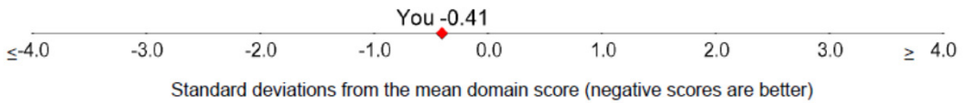
- Surprise – it is here (initially thought it would not “count” til ‘19
- Worth 10% for 2018 data – 2020 payment year
- Will use Claims data: Total cost and MSPB
- 1 point for yr. to yr. improvement
- It will include a full year of data – claims data
- 2018 data (2020 payment year) will have total per capita & MSPB
  - Remember that QRUR
  - While it will not count for payment – we have 8 episodes – 3 cardiac ones – for education and preparation for 2019 inclusion
    - Check those field tested episodes

The 2 factors for 2018 data year:

	Your TIN				All TINs in Peer Group	
Cost Measure	Number of Eligible Cases or Episodes	**Per Capita or Per Episode Costs**	Standardized Cost Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
Per Capita Costs for All Attributed Beneficiaries	387	**$10,230**	-0.59	Yes	**$12,380**	$3,631
Medicare Spending per Beneficiary	917	**$22,503**	1.71	Yes	**$20,411**	$1,220

Note: Only the measures for which your TIN had the minimum number of eligible cases or episodes are included in the domain score. For the Per Capita Costs for All Attributed Beneficiaries measure, the minimum number of eligible cases is 20. For the Medicare Spending per Beneficiary measure, the minimum number of eligible episodes is 125. The benchmark for a cost measure is the case-weighted national mean cost among all TINs in the measure's peer group during calendar year 2016. For the Per Capita Costs for All Attributed Beneficiaries measure, the peer group is defined as all TINs nationwide that had at least 20 eligible cases. For the Medicare Spending per Beneficiary measure, the peer group is defined as all TINs nationwide that had at least 125 eligible episodes.

From your QRUR



	Your TIN				All TINs in Peer Group	
Cost Measure	Number of Eligible Cases or Episodes	**Per Capita or Per Episode Costs**	Standardized Cost Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
Per Capita Costs for All Attributed Beneficiaries	310	**$8,181**	-1.16	Yes	**$12,380**	$3,631
Medicare Spending per Beneficiary	614	**$20,844**	0.35	Yes	**$20,411**	$1,220

Note: Only the measures for which your TIN had the minimum number of eligible cases or episodes are included in the domain score. For the Per Capita Costs for All Attributed Beneficiaries measure, the minimum number of eligible cases is 20. For the Medicare Spending per Beneficiary measure, the minimum number of eligible episodes is 125. The benchmark for a cost measure is the case-weighted national mean cost among all TINs in the measure's peer group during calendar year 2016. For the Per Capita Costs for All Attributed Beneficiaries measure, the peer group is defined as all TINs nationwide that had at least 20 eligible cases. For the Medicare Spending per Beneficiary measure, the peer group is defined as all TINs nationwide that had at least 125 eligible episodes.

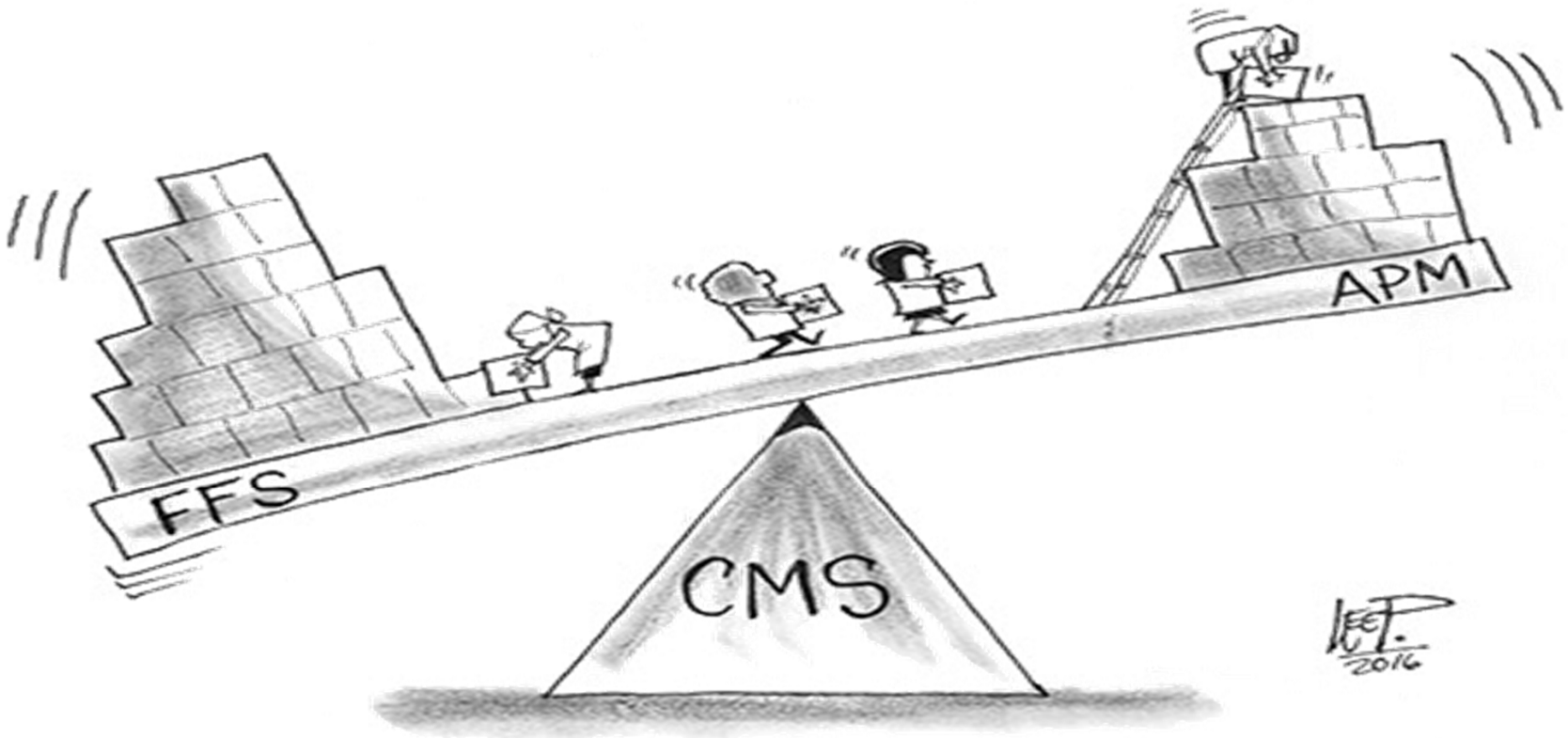
MIPS: 4th category: CPIA/IA

- New program for MIPS……. Replaces nothing
- Worth 15% of total MIPS score
- 40 points needed for full credit
  - Medium activity = 10 points and High activity = 20 points
- Some flexibilities in the final rule
  - <15 providers or practice in rural areas
    - Complete 2 activities for a minimum of 90 days
    - Medium activity = 20 points and High activity = 40 points

For Cardiology . . . Some Examples

INITIATIVE	SPECIFICS
Population management through a systematic anticoagulation program—high weight	Participation in a systematic anticoagulation program (eg, coagulation clinic, patient self-reporting program) for 60% of practice patients in Year 1 and 75% of practice patients in Year 2 who receive anticoagulation medications (warfarin or other anticoagulants)
Documented participation of patients in a systematic anticoagulation program. Could be supported by claims	1. Patients receiving anticoagulation medications - total number of patients receiving anticoagulation medications; and 2. Percentage of that total participating in a systematic anticoagulation program - documented number of referrals to a coagulation/anticoagulation clinic; number of patients performing patient self-reporting (PST); or number of patients participating in self-management (PSM)
Use of patient safety tools—medium weight	Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of a surgical risk calculator
Use of tools by specialty practices in tracking specific meaningful patient safety and practice-assessment measures	Documentation of the use of patient safety tools (eg, surgical risk calculator) that assist specialty practices in tracking specific patient safety measures meaningful to their practice

Alternative Payment Models (APMs)

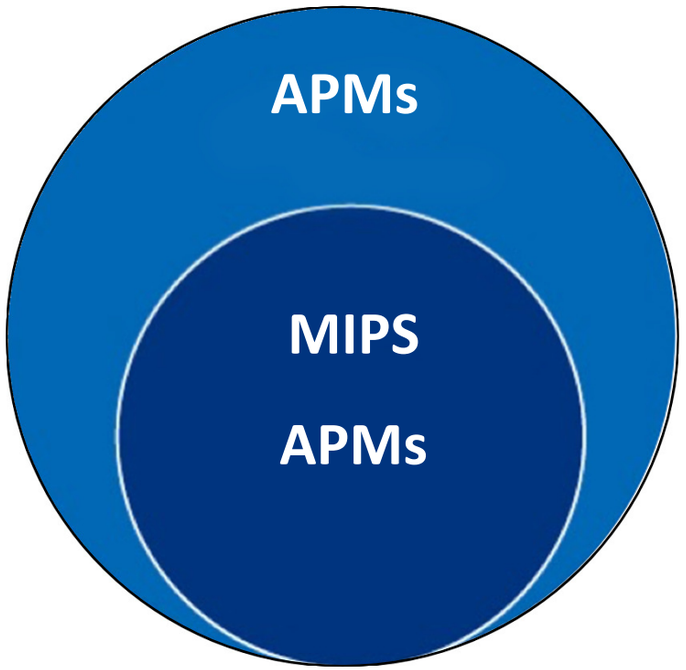


APMs

- APM is a generic term describing a payment model in which providers take responsibility for cost and quality performance and receive payments to support the services designed to achieve high value
- ACO's: accountable care organizations are a generic term
- There are Qualifying APMs and non-qualifying APM's. The Qualifying APM's in 2018 include:
  - Medicare Shared Savings Program ACOs – Track (1+), Track 2 & Track 3
  - CPCI +
  - Pioneer & Next Gen
  - Onc model
  - BPCI-A

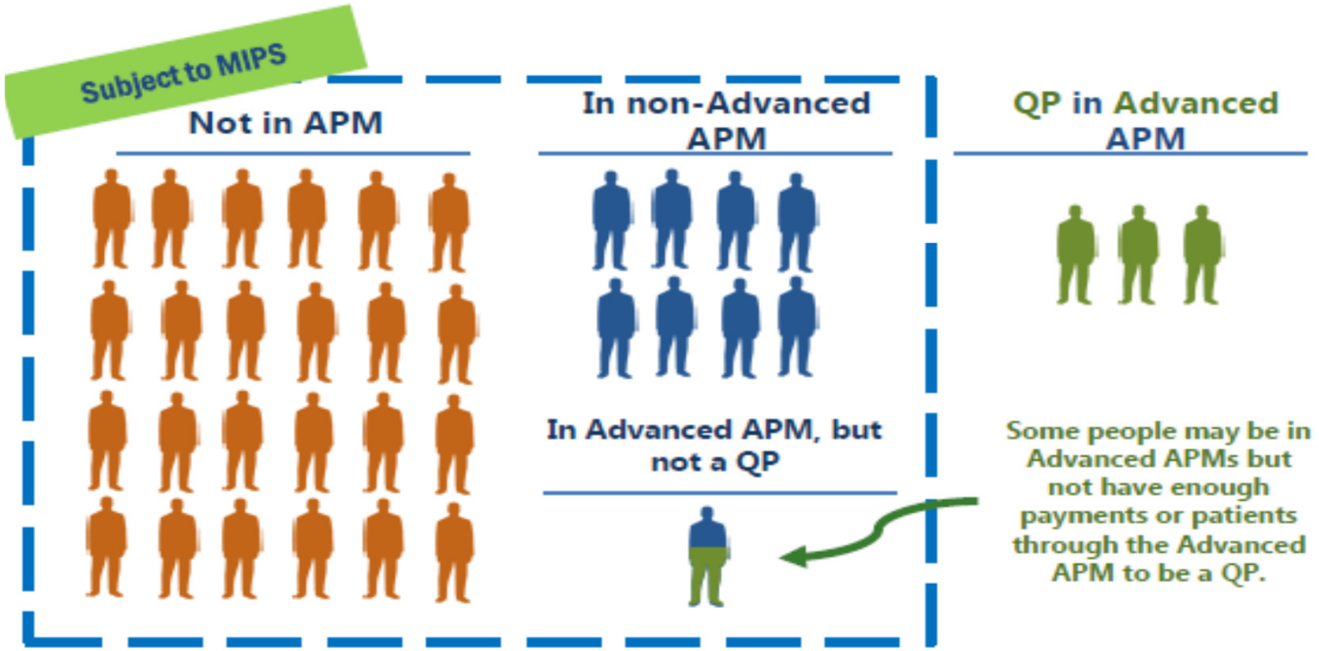
MIPS and APM

- Not in a qualifying ACO
- Not a qualifying provider
  - You will receive preferential scoring ☺
  - Full credit for IA – you attest
  - ACI/PI – you attest
  - Quality through your ACO
  - Cost through your ACO



Qualifying ACO *AND* Qualifying Provider

Note: Most clinicians will be subject to MIPS.



Are You MACRA/QPP Ready?.....Episode ready?

- Organizational focus
- Physician led process
- Prior success in
  - PQRS
  - MU
  - VM – QRUR and s-QRUR
- You have found your data
- You know your numbers
- Reducing variability in care delivery – MUST happen
- Understanding cost
- Understanding episodes of care
- Care coordination is an organizational priority
- Documentation for risk is a focus – clinic & hosp.

Physician compensation

- What if your comp was tied to your average risk score?
- Should comp be tied to ability to manage post acute care costs?
- Do physicians *really* have the ability to impact any of this?

Ready to jump in?

Public Reporting and you

Hospital Compare, Physician Compare, Open Payment Act, Medicare Part B payments, whynotthebest, NCDR,

YOUR Data

- https://www.medicare.gov/physiciancompare/
- https://www.cms.gov/openpayments/
- https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html

Physician Compare