TH8- Managing Quality Reporting in PA/LTC Medicine: Strategies for Selecting, Capturing, and Reporting Quality Metrics in Your Practice

Thursday, March 22
1:30 PM- 5:00 PM

Session Description

Quality measures are the largest determinant of your 'value' under all Medicare/Medicaid programs. Beginning with 2017, they determine how all physicians, APNs, and PAs are 'rated'. Those ratings follow you across all employment settings. Understanding how to manage your quality scores is becoming professionally critical. Each practitioner can be enrolled in multiple programs with different reporting requirements. You'll learn about managing quality for different audiences, reporting for regulatory purposes (CMS), and how to improve shared-patient care. This program is designed for clinical and administrative leaders with responsibility for quality reporting and quality strategies.

Learning Objectives

Select a menu of MIPS Quality Measures that are likely to yield better scores in 2018.
Describe the design of the quality metrics through the APM model, and how to participate.
Discuss how do practices contribute to I-SNP quality?
Identify how AMDA members can redefine PAC and LTC quality that's appropriate for patients, the practitioner, partners, and payors.

Presenter(s): Rod Baird, MS; Alex Bardakh, MPP; Dheeraj Mahajan, MD, CMD; Jean Butcher, MBA; Kerry Weiner, MD, MPH; Richard Feifer, MD, MPH; Rikki Mangrum, MLS; Steve Buslovich, MD, MS

Presenter(s) Disclosures: Rod Baird, MS: Has a financial disclosure; Geriatric Practice Mgt., LLC: President - salary and ownership interest; Steve Buslovich, MD, MS: Has a financial disclosure; Patient Pattern, Inc: Founder - software startup which performs frailty analytics; Jean Butcher, MBA: Has a financial disclosure; McQueen/Butcher Consulting: Consultant; All other speakers have reported they have no relevant financial relationships to disclose.
TH8 | Managing Quality Reporting in LT-PAC Medicine: Strategies for Selecting, Capturing, and Reporting Quality Metrics in Your Practice

Presenters: Dheeraj Mahajan, MD | Jean Butcher, MBA | Rod Baird, President

Speaker Disclosures

Rod Baird is the President of GPM, Inc. He has no other financial relationships to disclose.

Jean Butcher, MBA, is the VP and COO of Collaborative Geriatrics, Inc. She has no other financial relationships to disclose.

Dheeraj Mahajan, MD is the Chair, Quality Measures Sub-Committee at CIMPAR. He has no other financial relationships to disclose.

Session #1 Agenda

- Identifying Quality Measures that apply to LT-PAC Medicine
- Benchmarks – and why they are important
- How reporting strategies can increase Quality scores
- Individual vs. Group reporting
- Is the CMS Web Interface a viable option?
- Monitoring/Managing/Motivating Practitioner Behavior

Over Arching MIPS Issue

If you are a Medical Professional who is subject to MIPS:

You will receive a MIPS score as an individual

This MIPS score is derived from either:
1. Your Group's MIPS score
2. Your Individual MIPS score

Your Personal 2019 Medicare Payment Rate is adjusted by your MIPS Score – even if you change employment

MIPS scores matter more than you believe

I want to report quality – What measures do I pick?

The measure’s name, no matter how pertinent, is not the basis for selection!

1. Does the measure apply to the CPT® Codes you use?
   1. e.g. 99304-99306 and/or 99307-99310

2. Of the measures that apply, are they eligible for your chosen method of reporting?
   1. Claims, Registry, EHR

3. Does the measure ‘work’ for the population you treat?
   1. HA1c – do you manage your population to a value <9%?

4. Does the measure have a favorable benchmark?
   1. A >96.4% influenza immunization rate earns a full 10 points
   2. A 96.4 Falls Risk Assessment rate earns -6.3 points
   3. A 96.4 Dementia: Functional Status Assessment rate earns 3 Points (no benchmark)
MIPS Quality Measures that Apply to LT-PAC

- 99304-306 – 49 measures apply
- 99307-310 – 2 additional measures
- 99315-316, and 318 – only apply to 3 and 5 measures total
- G0438-439 (AWV) – applies to an additional 25 QMs

Claims vs. Registry vs. EHR by CPT Code

<table>
<thead>
<tr>
<th>CPT/HCPCS Code/Seq</th>
<th>Subsetting Method</th>
<th>Claims</th>
<th>Registry</th>
<th>EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304-306</td>
<td>31/32</td>
<td>5</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>99307-310</td>
<td></td>
<td>15</td>
<td>49</td>
<td>8</td>
</tr>
<tr>
<td>99315-316</td>
<td></td>
<td>37</td>
<td>51</td>
<td>8</td>
</tr>
<tr>
<td>99317</td>
<td></td>
<td>2</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>99318</td>
<td></td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>99319</td>
<td></td>
<td>22</td>
<td>58</td>
<td>8</td>
</tr>
<tr>
<td>99320</td>
<td></td>
<td>32</td>
<td>72</td>
<td>17</td>
</tr>
<tr>
<td>99321</td>
<td></td>
<td>24</td>
<td>73</td>
<td>17</td>
</tr>
<tr>
<td>99322</td>
<td></td>
<td>20</td>
<td>33</td>
<td>37</td>
</tr>
</tbody>
</table>

2018 Quality Measures POS 31/32 - Claims and Registry

- #001 Diabetes: Hemoglobin A1c Poor Control (Outcome)
- #005 – Heart Failure ACE Inhibitor or ARB Therapy for LVSD
- #047 Care Plan (High Priority)
- #007 CAD Beta Blocker
- #110 Influenza Immunization
- #154 – Falls Risk Assessment (High Priority)
- #155 Falls - Plan of Care (High Priority)
- #282-288 Dementia Measures (not benchmarked yet!)
- #181 Elder Maltreatment Screen and Follow-Up Plan (High Priority)
- #342 Pain Brought Under Control within 48 Hours – ALF [POS] only (Outcome)
- #290-294 Parkinson’s Disease Measures (not benchmarked yet!)
- #317 Preventive Care and Screening: Screening for High B/P & Follow-Up
- #332 Adult Sinusitis – Appropriate Antibiotic Selection (High Priority)
- #006 CAD Antiplatlet Therapy
- #067 CAD Beta Blocker

2018 POS 31/32 QMs - Registry Only

- #005 – Heart Failure ACE Inhibitor or ARB Therapy for LVSD
- #008 CAD Antiplatlet Therapy
- #007 CAD Beta Blocker
- #282-288 Dementia Measures (not benchmarked yet!)
- #290-294 Parkinson’s Disease Measures (not benchmarked yet!)
- #317 Preventive Care and Screening: Screening for High B/P & Follow-Up
- #332 Adult Sinusitis – Appropriate Antibiotic Selection (High Priority)
- #290-294 Parkinson’s Disease Measures (not benchmarked yet!)
- #342 Pain Brought Under Control within 48 Hours – ALF [POS] only (Outcome)

2018 AWV Quality Measures – in all POS

- #111 Pneumococcal Vaccination Status
- #121 BMI Screening
- #130 Documentation of Current Medications (High Priority)
- #131 Pain Assessment and Follow-Up (High Priority)
- #134 Screening for Clinical Depression

2018 Quality Measures POS 31/32 - Claims and Registry

- #001 Diabetes: Hemoglobin A1c Poor Control (Outcome)
- #005 – Heart Failure ACE Inhibitor or ARB Therapy for LVSD
- #047 Care Plan (High Priority)
- #007 CAD Beta Blocker
- #110 Influenza Immunization
- #154 – Falls Risk Assessment (High Priority)
- #155 Falls - Plan of Care (High Priority)
- #181 Elder Maltreatment Screen and Follow-Up Plan (High Priority)
- #317 Preventive Care and Screening: Screening for High B/P & Follow-Up

2018 Quality Measures POS 31/32 - Claims and Registry

- #001 Diabetes: Hemoglobin A1c Poor Control (Outcome)
- #005 – Heart Failure ACE Inhibitor or ARB Therapy for LVSD
- #047 Care Plan (High Priority)
- #007 CAD Beta Blocker
- #110 Influenza Immunization
- #154 – Falls Risk Assessment (High Priority)
- #155 Falls - Plan of Care (High Priority)
- #181 Elder Maltreatment Screen and Follow-Up Plan (High Priority)
- #317 Preventive Care and Screening: Screening for High B/P & Follow-Up

How do we Report – Group or Individually?

- Q: Are you acting like a group, or 2+ independent practitioners billing under a common TIN (Tax ID #)?
  - If you work as a group – Group Reporting is by far the best strategy
  - In addition to ‘sharing’ patients for Quality Measures,
    - Just 1 (one) Group Member can satisfy IA (Improvement Activity) for the entire Group
  - If you are not in a Group, or your Group is dysfunctional – then report Individually
  - There is a greater sum of labor required than Group Reporting BUT the most conscientious members will earn the higher scores

- Q: How do we report for diabetes?
  - A: In 2018, MIPS will have a new code for Hemoglobin A1c Poor Control (Outcome)
  - This code will be reported using the Diabetes Code (001) and the new Hemoglobin A1c Poor Control code (001)
  - Physicians can choose to report this code with or without the diabetes code
  - The diabetes code may be reported as a separate code or included as part of a bundled code

- Q: How do we report for falls?
  - A: In 2018, MIPS will have a new code for Falls Risk Assessment (High Priority)
  - This code will be reported using the Falls Code (154) and the new Falls Risk Assessment code (154)
  - Physicians can choose to report this code with or without the falls code
  - The falls code may be reported as a separate code or included as part of a bundled code

- Q: How do we report for screening?
  - A: In 2018, MIPS will have a new code for Preventive Care and Screening: Screening for High B/P & Follow-Up
  - This code will be reported using the Screening Code (317) and the new Preventive Care and Screening code (317)
  - Physicians can choose to report this code with or without the screening code
  - The screening code may be reported as a separate code or included as part of a bundled code
How Much of my MIPS Score is Based on Quality?

Weights After ACI Hardship Exemption

Why Ignore CMS Web Interface and EHR?

• Web Interface is analogous to ACO reporting – designed for a general population
  • Many measures are inappropriate for the LTC population
  • The individuals your group must report are determined ‘retrospectively’ by CMS using Claims Data
  • QED – reporting is very difficult to manage, or foresee

• EHR reporting via eCQMs is Vendor Specific
  • Only a few eCQMs ‘map’ to the CPT® codes 99304-310
  • EHR vendors can use other code sets, at their discretion, which may include FACE TO FACE visits in a SNF-NF setting
  • You must consult with your vendor to determine which eCQMs ‘work’

Small Group ‘JOG’ Pace MIPS Score Card

Large Group ‘JOG’ Pace MIPS Score Card

OK - How do we develop a MIPS Quality Reporting Strategy?
Jean Butcher, MBA
Vice President and COO, Collaborative Geriatrics, Inc.

Long Days Journey Into MIPS
- PQRS → MU → VBP → QPP (MIPS) → ?
- Increasing complexity
- Penalties if you don’t
- (possible) Incentives if you do
- Can use a similar approach each year to decipher the rules and develop a course of action

Our Case
- Mid-size independent practice (23 providers)
- Exclusively PA/LTC
- Low / No Infrastructure or ‘extra’ resources
- “Practiced” with PQRS reporting
  - First on paper (!)
  - Then through Registry (EMR)

2016 Performance VBP/VBM
- Multiple Quality Measures across Six Domains
- Quality Scores depended heavily on CMS Benchmarks
  - (many of which weren’t available!)
- Seemed overwhelming, but…

Accept The Things You Cannot Change And Work Hard On The Things You Can
- Unable to affect the Cost Attribution
- Can become skilled at Quality Reporting
- Can practice evidence-based, high-quality PALTC medicine with emphasis on reducing unnecessary rehospitalizations (what we do every day)

Strategy 2016 (and 2017-2018)
- Utilize a provider-centric PALTC EHR
- Align with smart people
  - State QIO
  - EMR resources
  - AMDA, other national organizations/webinars/education
- Strong Clinical Leader in the practice
- Continual learning, stay engaged, learn the ‘language’
**Action Steps (2016)**

- **Beginning of Year:** examine and select QM’s
  - Best result/score, least hassle for providers
- **Educate providers**
  - What, Why and How to answer QM’s
- **Implement 90-day data gathering period**
  - Monitor, coach, educate
  - Access QRUR Feedback Report for previous year
- **End of year:** final strategy-check and report the required, compliant and most advantageous data

**2016 Performance Results**

- **High Quality**
- **High Cost**

**2018 Value Modifier**

- **Neutral Adjustment (0.0%)**

**2016 Value Modifier Results, Quality Designation**

1,351,353 Total Clinicians Nationally

- High Quality
- Average Quality
- Low Quality
- Failed (Reporting)

**2017 MIPS**

- 90 day reporting period (or greater, but who would do that?)
- **IA:** 1 EP performs, all get credit
- **ACI:** similar to MU – or – take Hardship Exception
- **QM:** Quality Reporting skills
- **Cost:** 0% of score
- **100 Point Scale (total)**

**2017 Action Plan**

- **Beginning of Year:** examine and select QM’s
  - Best result/score
  - Least difficulty
- **Educate providers**
  - What, Why and How to answer QM’s
- **Implement 90-day data gathering period**
  - Monitor and coach
- **End of year:** final strategy-check and report the required, compliant and most advantageous data

**We Knew…**

- Score 3 points or higher avoids -4% financial penalty
- Score of 3-69 becomes eligible for possible positive $ payment adjustment
- Score of 70 points and higher eligible for positive payment adjustment plus possible additional $ payment
Example MIPS Dashboard

2017 Performance Result =
MIPS SCORE of 100
via CMS Web Portal reporting

• Report MIPS data to avoid -5% penalty
• Goal: high MIPS Score
  • Again, 100 Point Scale (total)
  • Score reported publicly
  • Possible bonus dollars
• Strategy
  • Select 6 suitable Quality Measures (full year reporting)
  • Take Hardship Exception for ACI
  • Perform 90 days of IA
  • Hope for the best on CMS Cost calculation

Selecting Quality Measures To Report

2018 MIPS

- Which Apply to PALTCC? (CPT Codes)
- Of These, Which Have Benchmarks? (rule out any w/o)
- Of These, Which Are Achievable?
  - > 60% Patients, Inf 20 Cases: Good Quality Answers
- Of These, Which Are 'Least Hassle' for Providers/Practice to Perform?

Selecting Quality Measures To Report

2018 MIPS QM Refinement

<table>
<thead>
<tr>
<th>Measure ID #</th>
<th>Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</td>
</tr>
<tr>
<td>6</td>
<td>Coronary Artery Disease (CAD) Antiplalet therapy</td>
</tr>
<tr>
<td>47</td>
<td>Care Plan</td>
</tr>
<tr>
<td>110</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
</tr>
<tr>
<td>154</td>
<td>Falls: Risk Assessment</td>
</tr>
<tr>
<td>155</td>
<td>Falls: Plan of Care</td>
</tr>
<tr>
<td>181</td>
<td>Elder Malnutrition Screen and Follow-Up Plan</td>
</tr>
<tr>
<td>326</td>
<td>Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy</td>
</tr>
<tr>
<td>332</td>
<td>Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)</td>
</tr>
</tbody>
</table>

The Devil is in the Details

• QM Specification Sheets
• Applicable CPT Codes (places of service)
• "Quality" Of Potential Answers – this is very important
  - Performance Met
  - Performance Exclusion
  - Performance Not Met
Every QM has “good quality” answer/s and “poor quality” answer/s. Some also have “exclusions.”

Example: QM #47 Care Plan

Potential Answers:

- Educate Providers
- If a “good quality” answer isn’t applicable to the patient, better to skip reporting that patient (remember, only 60% reporting threshold is required)
- If an “exclusion” applies, it is safer to skip reporting that patient (same as above)
- Monitor and coach throughout year
- End of year: final strategy-check (which QM to submit), then report the required, compliant and most advantageous data

Answer QM(s) on 60% or More Eligible Patients

- Planned 2018 Strategy, including QM’s
- Found out in February: participating in a Track 1 MSSP ACO for 2018
- Which means:
  - Still report IA, ACI, (Cost) at group level
  - But will report ACO Quality Measures through the ACO
  - And ACO QM’s are different!

Strategy

- Utilize a provider-centric PALTC EHR
- Automate data collection
- Learn / access resources
  - Such as: State QIO, EMR resources, AMDA, other national organizations / webinars / education
- Stay engaged, educate providers, learn the ‘language’
- Exercise QM Reporting skills

Key Take-aways

- It’s not too late to start 2018 QM Reporting!
- Choose 6 measures
- Report on at least 60% of patients from Jan.-Dec.
- Control what you can
  - No ‘poor quality’ answers on QM’s
  - Monitor the rules and the landscape — they change, often without notice
  - Stay engaged, practice the skills
SESSION #2 - How does ACO Quality differ from MIPS?
- Is it possible to effect changes in CMS Quality Measures?
- Does CAHPS apply to LTC?
- How does Risk Adjustment Count?
- The role of Risk in MIPS

Presenters: Richard Feifer, MD, MPH, FACS, Chief Medical Officer
Kerry Weiner, MD, MPH, Senior Medical Executive

Richard Feifer is the CMO at Genesis HealthCare. He has no other financial relationships to disclose.

Kerry Weiner is a Senior Medical Executive at Avante Healthcare Consulting. He has no other financial relationships to disclose.

Genesis HealthCare Overview

Key Facts
- 450+ facilities across 30 states
- ~60,000 beds
- ~80,000 dedicated employees
- 200+ clinical specialty units.
- 550+ Genesis physicians and physician associates.
- Genesis also supplies contract rehabilitation services to approx. 1,700 locations across 46 states.

Medicare Shared Savings Program (MSSP) ACO

Current MSSP Attribution Rules:
- Plurality of primary care charges
- Excludes POS 31 – skilled
- Includes POS 32 – unskilled, LTC

ASSIGNMENT LOGIC
- Step 1 - For patients who have received primary care services from any primary care practitioner during the year
  - Plurality of primary care charges from primary care practitioners (combined) within the ACO
  - Abb at least 1 primary care service from an ACO physician
- Step 2 - For patients who have not received primary care services from any primary care practitioners during the year
  - Plurality of primary care charges from specialist physicians (combined) within the ACO

DEFINITIONS
- Primary Care Service = 99xxx codes and wellness visits
- Primary Care Practitioner = primary care physician (IM, GP, FP, Geriatrics), NP, or PA
MSSP Quality Measures

31 quality measures are separated into the following four key domains that will serve as the basis for assessing, benchmarking, rewarding, and improving ACO quality performance:

- Denominator Exclusion – patient is not included in the denominator during sampling, based on predefined criteria within the measure definition (e.g., male for breast cancer screening)
- Denominator Exception – patient is eligible for the measure based on inclusion and exclusion definitions; however, the provider identifies and documents the presence of a patient specific factor pre-defined by CMS for certain measures (e.g., allergy to the influenza vaccination)
- QNET “Patient Skip” Request – patient is eligible for the measure based on inclusion and exclusion definitions; however, the provider identifies and documents the presence of a patient specific factor, which the ACO can submit to CMS, requesting to “skip” the patient during reporting. These requests are evaluated individually for each patient based on the clinical rationale provided.

What if the measure doesn’t apply to the patient?

- Denominator Exclusion – patient is not included in the denominator during sampling, based on predefined criteria within the measure definition (e.g., male for breast cancer screening)
- Denominator Exception – patient is eligible for the measure based on inclusion and exclusion definitions; however, the provider identifies and documents the presence of a patient specific factor pre-defined by CMS for certain measures (e.g., allergy to the influenza vaccination)
- QNET “Patient Skip” Request – patient is eligible for the measure based on inclusion and exclusion definitions; however, the provider identifies and documents the presence of a patient specific factor, which the ACO can submit to CMS, requesting to “skip” the patient during reporting. These requests are evaluated individually for each patient based on the clinical rationale provided.

GRPO Measures that allow for exceptions per CMS for 2018

- CARE 2 – Falls: Screening for Future Fall Risk
- PREV 7 - Preventive Care and Screening: Influenza Immunization
- PREV 9 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- PREV 10 – Tobacco Use: Screening and Cessation Intervention
- PREV 12 - Screening for Clinical Depression and Follow-up Plan
- PREV 13 - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

ACO Quality Measures Workflow

- ACO Quality Measures Workflow
- ACO Quality Measures Workflow
- ACO Quality Measures Workflow
- ACO Quality Measures Workflow

What if the measure doesn’t apply to the patient?

- Denominator Exclusion – patient is not included in the denominator during sampling, based on predefined criteria within the measure definition (e.g., male for breast cancer screening)
- Denominator Exception – patient is eligible for the measure based on inclusion and exclusion definitions; however, the provider identifies and documents the presence of a patient specific factor pre-defined by CMS for certain measures (e.g., allergy to the influenza vaccination)
- QNET “Patient Skip” Request – patient is eligible for the measure based on inclusion and exclusion definitions; however, the provider identifies and documents the presence of a patient specific factor, which the ACO can submit to CMS, requesting to “skip” the patient during reporting. These requests are evaluated individually for each patient based on the clinical rationale provided.

What if the measure doesn’t apply to the patient?

- Denominator Exclusion – patient is not included in the denominator during sampling, based on predefined criteria within the measure definition (e.g., male for breast cancer screening)
- Denominator Exception – patient is eligible for the measure based on inclusion and exclusion definitions; however, the provider identifies and documents the presence of a patient specific factor pre-defined by CMS for certain measures (e.g., allergy to the influenza vaccination)
- QNET “Patient Skip” Request – patient is eligible for the measure based on inclusion and exclusion definitions; however, the provider identifies and documents the presence of a patient specific factor, which the ACO can submit to CMS, requesting to “skip” the patient during reporting. These requests are evaluated individually for each patient based on the clinical rationale provided.
The Importance of CMS Advocacy

Medical Applicability of Quality Measures

CANCER SCREENING

- Long Term Care ACO Patient Characteristics
  - Median age 82
  - Multiple comorbidities & dementia
  - Median length of stay = 2 years, prior to death
  - Over 94% never return to the community

- The Problem
  - PREV-5 Breast Cancer Screening and PREV-6 Colorectal Cancer Screening
  - Evidence and guidelines recommend AGAINST screening when life expectancy < 10 years (ACS, AMDA, SGIM)
  - NCQA leaders explicitly state that this should be addressed by CMS within measure "Guidance" section

- Potential Solution
  - Allow exceptions for life expectancy < 10 years for screening measures

MEDICATION RISK/BENEFIT

- Long Term Care ACO Patient Characteristics
  - Median age 82
  - Multiple comorbidities & dementia
  - Median length of stay < 2 years, prior to death
  - Over 94% never return to the community

- The Problem
  - Polypharmacy and "adverse drug events" (ADEs) are pervasive - 1.9 million ADEs/year in US nursing homes
  - "De-prescribing" is a top priority, with careful attention to risks vs benefits for each patient
  - Several metrics do not allow for patient-level exceptions based on careful consideration of medication intolerance and risk/benefit evaluation

- Potential Solution
  - Allow for patient-level exceptions
    - Medication intolerance
    - Goals of care and life expectancy
    - Applicable metrics
      - DM2 HbA1c
      - HTN2 Hypertension
      - IVD2 IVD Antithrombotic

CAHPS

- Long Term Care ACO Patient Characteristics
  - Median age 82
  - Multiple comorbidities & dementia
  - Median length of stay = 2 years, prior to death
  - Over 94% never return to the community

- The Problem
  - CAHPS is required by MSSP but paradoxically excludes nursing home patients
  - Minuscule sample size of non-representative patients, leading to statistically insignificant results

- Potential Solutions
  - Short term
    - Option A: Full carve-out of CAHPS domain when a significant proportion (e.g., >50%) of an ACO population is ineligible
  - Option B: Establish statistically valid threshold for confidence intervals of survey results, and redistribute QM requirements if not satisfied
  - Long term
    - Develop an alternate survey of provider access and experience that is valid and applicable for nursing home patients
Learning Objectives

• Goals of Clinical Risk Adjustment Methodologies
• History of the HCC System
• Limitations
• High Level Review of Mechanics and Successful Strategies

HCC - Hierarchical Condition Categories
Medicare’s Clinical Risk Adjustment for Population Payment

The Playing Field for Different Populations at Risk

HCC Goals: Risk Adjust for Relative Cost of Different Disease States

• Insure appropriate compensation to deliver care
• Predicts future health costs
• Dis-incentivize programs to select healthy population
• Mitigate impact of adverse selection
• Improve quality measurement methodology
CMS-HCC Risk Adjustment Model

- Economic Model Designed Modify MA capitation
  - Arlene Ash, Randall Ellis @ Boston University 2000
  - Based on historic cost of chronic disease burden
  - Adjusted and normalized every 2 years
  - Captures 35% of variance in cost
- Based on FFS Medicare population
  - RAF score 1.0 = average Medicare patient score
  - > 1.0 = sicker population
  - < 1.0 = healthier population
- Sensitive to population, access, benefits & upcoding
  - Not applicable to specialties, younger population, etc.
  - Captures 18% for Quality Measure Variation

HCC Model incorporated in All Medicare Risk Programs

- Medicare Advantage Capitation and Quality adjustments
- Benchmarking in APMs, especially ACOS
- Denominator adjustments for MIPS Quality and Utilization Measures

Hierarchical Condition Categories (HCC)

- ICD 10 codes (68,828)
  - No weighting
- HCC DX codes (8,830 reimbursable ICD codes)
  - HCC codes assigned weighting
- 79 Hierarchical Condition Categories
  - HCC codes mapped to Condition Categories with risk-adjusted factor (RAF)

RAF Score is Sum of Components Defines Relative Cost Risk of Patient

- Most Additive
  - Some supersede others
- Demographics
  - Age, sex, disability
- Interactions
  - CHF & DM, COPD & Asp. PN, CHF & Renal

HCC Impact To Risk Sharing

<table>
<thead>
<tr>
<th>High level specificity</th>
<th>Moderate level specificity</th>
<th>Low level specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 year old female</td>
<td>0.303</td>
<td>60 year old female</td>
</tr>
<tr>
<td>Medicare eligible (aged female 65+)</td>
<td>0.267</td>
<td>Medicare eligible (aged female 65+)</td>
</tr>
<tr>
<td>Diabetes w/ complications, Vascular disease with complications, COPD &amp; Asp. PN (HCC 184)</td>
<td>0.123</td>
<td>Diabetes w/ complications, Vascular disease with complications, COPD &amp; Asp. PN (HCC 184)</td>
</tr>
<tr>
<td>Total RAF</td>
<td>3.721</td>
<td>Total RAF</td>
</tr>
</tbody>
</table>

Coded for most severe manifestation among related diseases
- Categories are generally added but not always
- Acute trumps chronic complications
- Condition interactions reflect additional costs.
  - CHF & COPD, COPD & Asp. PN, CHF & RF

Derived from CMS 2017 data
**DX and Coding Requirements**

- Face to Face encounter
- Legible signature and credentials of provider
- Manage, Evaluate, Access, Treat (MEAT)
- Linkage, specificity important
  - Link tests, treatments to problem
  - Casual relationship of diagnoses

**HCC Strategies**

- Make sure every beneficiary evaluated 1/yr.
  - Homebound
  - LTC
- Technology to capture existing chronic conditions
- Gap analysis and corrective actions
- Incentivize front line providers
- Educate everyone involved; develop collaterals
- Focus on sickest patients
- Near real-time audits

**A Few More Pearls…**

- Record must document causality, linkage, activity
  (specialty consultation notes important)
- RADV: Risk Adjustment Data Validation
  - Gaps extrapolated to the entire population

**Aristotle’s Challenge**

Anyone can become angry—that is easy. But to be angry with the right person, to the right degree, at the right time, for the right purpose, and in the right way—this is not easy.

—Aristotle, The Nicomachean Ethics

**AMDA’s Best Thinking About Measures that Matter**

**Speaker Disclosures**

Steven Buslovich, MD, MSCP.M, is Co-Founder and CEO of Patient Pattern. He has no other financial relationships to disclose.

Dheeraj Mahajan, MD is employed by CIMPAR. He has no other financial relationships to disclose.

Rikki Mangrum, is a Senior Researcher, at Domestic American Institute for Research. She has no other financial relationship(s) to disclose.
Quality That Matters

Steven Buslovich, MD, MSHCPM
Geriatrician employed by TeamHealth
Co-founder, CEO of Patient Pattern

Faced With A Quality Challenge

Improve a 2-Star 300-bed inner-city hospital-owned facility with an ISNP population
Reduce rehospitalizations
Limited data sources
Over-extended medical staff

Quality and Outcome Ratings Matter More

Our Industry Today
Patients becoming increasingly complex
Competition for preferred health system
More participation in shared risk programs

The Impact for Providers
Outcomes are driving reimbursement (VBP)
Single disease guidelines provide limited value
Risk assessment during encounters needed
Information, communication and throughput challenges

How can quality be improved at the bedside, not in the back office?

Measuring What Matters

1. POLYPHARMACY
2. ER UTILIZATIONS
3. RE-HOSPITALIZATIONS: 30, 60 AND 90 DAY
4. SHORT-STAY MORTALITY
5. WOUND RATES
6. PSYCHOTROPIC RATES
7. ADVANCE CARE PLANNING
8. EXPECTATIONS AND SATISFACTION
9. LITIGATION CLAIMS
10. FRAILTY

Impacting Care
Complex Populations
Triple Aim

Focusing on the and not the

- Moving healthcare from single-organ focus
- To multisystem, multi-organ care approach
- Organized around the physiology of frailty
- Used to deliver appropriate care

Frailty is an Under-Recognized Chronic Condition

- Prognostication for frail older adults with chronic illnesses is complex, especially when they become seriously ill

- Knowing the frailty status is better than age to determine if a patient is likely to benefit from a treatment or be harmed [Theou, Rockwood, 2012]

- As Frailty increases, potential for recovery decreases [Theou, Rockwood, 2012]
**Why is Frailty Important? (US and International Demographics)**

![Graph showing prevalence and 10-year outcomes of frailty in older adults in relation to deficit accumulation.](image1)

**What is Frailty Risk Scoring?**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Clinical Validation</th>
<th>Focus in Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frailty Risk Score: A measure of vulnerability, a mathematical model of physiological age, based on deficit accumulation.</td>
<td>Internationally validated over last 30 years. Used more in Canada, Australia, China, UK. Geriatrics, Orthopedic, Cardiac, Nephrology, Surgery, and Trauma. Across care settings.</td>
<td>Benefits: Enhance quality in late life, respect patient and family priorities, prevent premature loss of function, avoid non-beneficial care, frame advance care discussions, improve setting metrics.</td>
</tr>
</tbody>
</table>

**Frailty Risk Score: 57.69% - Approaching the end of life**

The Frailty Index is reported on a continuum and is calculated from a comprehensive patient assessment. A score of 50% or over identifies someone who is either extremely frail, at baseline, or recovering from hospitalization. If extremely frail, at baseline, it is unlikely they will return to previous health and function. Their medical status may decline rapidly with the next illness - even if minor. They will do better remaining in the facility with avoidance of discomfort. Completing Advance Care Documents is a priority.

The following deficits have contributed to this degree of vulnerability:
- Weakly
- Falling
- Grazing
- Toileting
- Incontinence
- Presence of Frailty Catheter

**Team Approach**

- In an iSNP environment
  - Use crude Health Risk Assessment
  - Goals and approach are different
  - All disciplines are partnered
  - Resources are shared
  - Enhanced patient/family communication
  - Goals are patient driven, not disease driven

**Palliative Care**

**FRAIL**
Highpointe Quality Analysis

Figure 1. Age distribution of the study sample (n=537)

Figure 2. Distribution of FI in the study sample (n=537)

Figure 3. Readmission rate by quarter (n=596)

Figure 4. Death rate by quarter (n=596)
Summary

- Identifying and measuring "true" quality metrics is key to success
- Go beyond what has been historically defined as useful data
- Obtain current clinical data from facilities and EHR
- Focusing on patients' goals rather than the disease improves satisfaction
- Setting patient/family expectations reduces malpractice claims
- Measuring frailty in practice can create a road map to deliver more appropriate level of care and mitigate risk for poor outcomes

Look Forward

QUALITY PAYMENT PROGRAM OVERVIEW

Dheeraj Mahajan
Chair, Quality Measures Sub-Committee
@CIMPAR

Slide-Deck Courtesy: Jean Moody - Williams, RN, MPP (CMS)
Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov.

**Quality Payment Program**

**CMS Priorities**

- Improve beneficiary outcomes
- Increase adoption of Advanced APMs
- Improve data and information sharing
- Reduce burden on clinicians
- Maximize participation
- Ensure operational excellence in program implementation
- Deliver IT systems capabilities that meet the needs of users

**MACRA**

Medicare Access and CHIP Reauthorization Act of 2015

(MACRA) significantly changes how Medicare will reimburse physicians in the future, emphasizing quality, value, and physicians taking more financial risk.

- CMS estimates savings of $33.5 trillion saved over 10 years.
- Medicare targets 5% payments to pay-for-performance doubled to 10% by 2018.

- Repeals SGR (Sustainable Growth Rate)
- Extends CHIP (Children's Health Insurance Program)
- Shifts FFS to P4P (Medicare shifts from fee-for-service to pay-for-performance)

**MIPS**

Medicare Physician Fee Schedule

- **Legacy System:** Three separate systems
- **New System:** One composite score and report

- Meaningful Use of EHR
- Quality
- Resource Use
- Value-Based Modifiers
- P4P (Physician Quality Reporting System)

**APM**

Alternative Payment Models

- Value-based payment models that emphasize providers on quality, outcomes, and cost containment.
- Bundles:
  - Accountable care organizations
  - Medical homes

**MIPS Year 2 (2018)**

Who is Included?

No change in the types of clinicians eligible to participate in 2018.

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
**MIPS Year 2 (2018)**

**Who is Included?**

*Change to the Low-Volume Threshold for 2018.* Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges AND providing care for more than 200 Medicare patients a year.

**Transition Year 1 (2017)**

- **Final**
  - Billing $<90,000 AND <100
- **Year 2 (2018) Final**
  - Billing $>90,000 AND >200

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.

**Who is Exempt?**

*No Change in Basic Exemption Criteria*

- Newly enrolled in Medicare
- Below the low-volume threshold
  - Medicare Part B allowed charges less than or equal to $90,000 a year
  - OR
  - Successfully treated 200 or fewer Medicare Part B patients a year
- Significantly participating in Advanced APMs
  - Receive 25% of their Medicare payments
  - OR
  - See 20% of their Medicare patients through an Advanced APM

*If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.*

**Virtual Groups**

- **Options**
  - Individual
  - Group
  - Virtual Group

1. Individual: under an NPI, Medicare administrative billing (MAB) is a single provider where they receive payments
2. Group: 2 or more clinicians (MIPs) who have reassigned their billing rights to a single TIN
3. A Virtual Group: made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together virtually through a written agreement to participate in MIPS for a performance period for a year.

*If clinicians participate as a group, they are assessed as a group across all MIPS performance categories. The same is true for clinicians participating as a Virtual Group.*

**What else do I need to know?**

- Participation in 2018:
  - A virtual group must have been made before the start of the 2018 performance period and include at least the information about each TIN and NPI associated with the virtual group and the virtual group representative’s contact information.
  - A virtual group’s official representative is needed to acknowledge that a formal written agreement has been established between each solo practitioner and group that composes a virtual group.
  - Once the election is made, the virtual group representative must contact the Quality Payment Program Service Center before the applicable submission period starts with any updates to the election information for the applicable performance period.
MIPS Score
Four categories, one composite score and report

- Quality
- Resource Use
- Clinical Practice Improvement Activities (COST)
- Advancing Care Information (ACI)

MIPS Performance Categories for Year 2 (2018)

- Quality: 50
- Cost: 10
- Improvement Activities: 15
- Advancing Care Information: 25

100 Possible Final Score Points

- Comprised of four performance categories in 2018.
- So what? The points from each performance category are added together to give you a MIPS Final Score.
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a positive, negative, or neutral payment adjustment.

MIPS Year 2 (2018)


Change: Increase in Performance Period

- Improvement Activities: 90-days
- Advancing Care Information: 90-days
- Quality: 12-months minimum; full year (12 months) was an option
- Cost: Not included. 12-months for feedback only

Performance Period for Year 2 (2018)

- Performance period opens January 1, 2018.
- Closes December 31, 2018.
- Clinicians care for patients and record data during the year.

Deadline for submitting data is March 31, 2019.
- Clinicians are encouraged to submit data early.
- CMS provides performance feedback after the data are submitted.
- Clinicians will receive feedback before the start of the payment year.

MIPS Year 2 (2018)

Timeline for Year 2

- Feedback available January 1, 2020
- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2020.
March 31st 2018, does that ring a Bell?

**SUBMISSION DEADLINE**

---

**Year 1 Submission is currently underway**

Visit qpp.cms.gov and look for the login icon at the top of the screen.

Clinicians who participate in the Quality Payment Program have one place to submit all of their data eliminating the need for multiple visits to multiple websites.

---

**Reporting Data for the Quality**

Clinicians will use real-time initial scoring within the Merit-based Incentive Payment System (MIPS) performance categories based on their submissions.

---

**Reporting Data for the Advancing Care Information Performance Category**

You must attest to the first two statements in order to continue submitting data for the Advancing Care Information performance category.

---

**MIPS Year 2 (2018)**

Reporting and Data Submission Options

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Mechanisms for Individuals</th>
<th>Submission Mechanisms for Groups (Including Virtual Groups)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement Activities</td>
<td>Attestation</td>
<td>QCDR Qualified Registry, EHR, CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>Cost Improvement Activities</td>
<td>Attestation</td>
<td>QCDR Qualified Registry, EHR, CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>Clinical Process Improvement Activities</td>
<td>Attestation</td>
<td>QCDR Qualified Registry, EHR, CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>Care Coordination Improvement Activities</td>
<td>Attestation</td>
<td>QCDR Qualified Registry, EHR, CMS Web Interface (groups of 25 or more)</td>
</tr>
</tbody>
</table>

---

**MIPS Year 2 (2018)**

No change: All of the submission mechanisms remain the same from Year 1 to Year 2

- Continue with the use of submission mechanisms per performance category in Year 2 (QPP), Same policy as Year 1.
- The use of multiple submission mechanisms per performance category is available in Year 1 (QPP).
### MIPS Year 2 (2018)

**Performance Categories**

**Quality**

- **Component Transition Year 1 (2017)**
  - Performance Category Weight is finalized at 50% for submission.
  - New measures will be included in the next year.
  - Old measures will remain at 2016 performance.

- **Year 1 (2018)**
  - Measures that do not meet data completeness criteria earn 0 points.
  - Measures that do not meet the data completeness criteria earn 3 points.
  - High-priority measures that do not meet the data completeness criteria earn 6 points.

**Topped Out Measures**

- These measures were used in the Value Modifier and in the MIPS performance category score for 2018.

- We are developing new episode-based measures with significant clinician input and are providing feedback on these measures this fall through field testing.

- This will allow clinicians to see their cost measure scores for the next year.

- We will propose new cost measures in future rulemaking.

- The 7-point scoring policy for the 6 topped out measures identified for 2018 performance period will not be used.

- We are developing new episode-based measures with significant clinician input and are providing feedback on these measures this fall through field testing.

- This will allow clinicians to see their cost measure scores for the next year.

- We will propose new cost measures in future rulemaking.

**Quality**

- Change: 95% of Final Score in 2018
- 270+ measures available
- You select 6 individual measures
- High-priority measure
- Specialty-specific set of measures

**What is the significance?**

- 1 must be an Outcome measure
- Majority of MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians.

**Change**

- Baseline
  - 50% for submission
  - 50% for final score
  - Measure in performance can no longer be made.

- Distinctions and improvement topped out if meaningful distinctions and improvement cannot be made.

**Basics**

- Change: 95% of Final Score in 2018
- 270+ measures available
- You select a specialty-specific set of measures

**Topped out policies**

- Topped out measures will only be removed after a review of policy and additional considerations.

- Topped out policies do not apply to CMS Web Interface measures, but this will be monitored for differences with other submission options.

**Quality**

- Change: 95% of Final Score in 2018
- 270+ measures available
- You select 6 individual measures
- High-priority measure
- Specialty-specific set of measures

**What is the significance?**

- 1 must be an Outcome measure
- Majority of MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians.

**Topped out measures**

- Measures that do not meet data completeness criteria earn 0 points.
- Measures that do not meet the data completeness criteria earn 3 points.
- High-priority measures that do not meet the data completeness criteria earn 6 points.

**Basics**

- Change: 95% of Final Score in 2018
- 270+ measures available
- You select a specialty-specific set of measures

**Topped out policies**

- Topped out measures will only be removed after a review of policy and additional considerations.

- Topped out policies do not apply to CMS Web Interface measures, but this will be monitored for differences with other submission options.
### MIPS Year 2 (2018)

#### Advancing Care Information

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>25% of Final Score in 2016</td>
<td>Composed of Base, Reform, and Bonus score</td>
</tr>
<tr>
<td></td>
<td>Promotes patient engagement and the electronic exchange of information using certified EHR technology</td>
</tr>
<tr>
<td></td>
<td>Two measure sets available, chosen from based on EHR edition</td>
</tr>
</tbody>
</table>

### MIPS Year 2 (2018)

#### Cost

<table>
<thead>
<tr>
<th>Scoring/Scoring</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each individual MIPS eligible clinician’s and group’s cost performance will be calculated using all eligible claims and if they meet the core minimum of at least five patients</td>
<td></td>
</tr>
<tr>
<td>Individual MIPS eligible clinicians and groups are not required to submit any additional information for the cost performance category</td>
<td></td>
</tr>
<tr>
<td>Performance is compared against performance of other MIPS eligible clinicians and groups, and performance period data is not based on a pair-wise comparison</td>
<td></td>
</tr>
<tr>
<td>Performance category score is the average of the two measures: Medicine Spending per Beneficiary (MSPB) and total per capita cost measures</td>
<td></td>
</tr>
<tr>
<td>If any one measure can be scored, it will serve as the performance category score</td>
<td></td>
</tr>
</tbody>
</table>

### MIPS Year 2 (2018)

#### Scoring Improvements

### MIPS Year 2 (2018)

#### Improvement Activities

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Activities</td>
<td>No change in the number of activities that MIPS eligible clinicians must report in 2018 compared to 2017</td>
</tr>
<tr>
<td></td>
<td>All Improvement Activities are eligible for a 10% Advancing Care Information bonus for completion of at least 1 of the specified Improvement Activities using CEHRT</td>
</tr>
<tr>
<td></td>
<td>For virtual group reporting: only one MIPS eligible clinician in a virtual group must perform the Improvement Activity for the TIN to receive credit</td>
</tr>
<tr>
<td></td>
<td>For group reporting, only one MIPS eligible clinician in a TIN must perform the Improvement Activity for the TIN to receive credit</td>
</tr>
<tr>
<td></td>
<td>Improvement will be measured at the performance category level</td>
</tr>
<tr>
<td></td>
<td>Improvement scoring will be based on the rate of improvement such that higher improvement results in more points for those who have not previously performed well</td>
</tr>
<tr>
<td></td>
<td>Improvement scoring will be based on statistically significant changes at the measure level</td>
</tr>
<tr>
<td></td>
<td>Up to 10 percentage points available in the Quality performance category</td>
</tr>
</tbody>
</table>

### MIPS Year 2 (2018)

#### CEHRT Requirements

<table>
<thead>
<tr>
<th>CEHRT Requirements</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS eligible clinicians may use either the 2014 or 2015 CEHRT as a combination in 2016</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A CEHRT is available for using either 2015 or 2017 Clinical Version (CEV)</td>
</tr>
<tr>
<td>Measures and Objectives</td>
<td>CMS specifies exclusions for the FHIR billing and health information exchange measures</td>
</tr>
<tr>
<td></td>
<td>No change to the performance requirements for the 2018 performance period 2018 payment year</td>
</tr>
<tr>
<td></td>
<td>For the 2019 performance year, MIPS eligible clinicians and groups can select either the 2017 or 2018 CEHRT for reporting in 2018</td>
</tr>
<tr>
<td></td>
<td>Reporting of Clinical Quality Measures Reporting measures as part of the performance year</td>
</tr>
<tr>
<td></td>
<td>Reporting of CEHRT in 2018 is available for reporting to an additional registry or reporting to more than one registry</td>
</tr>
<tr>
<td>Additional Improvement Activities are eligible for a 10% Advancing Care Information performance category bonus for completion of at least 1 of the specified Improvement Activities using CEHRT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Two measure sets available, chosen from based on EHR edition</td>
</tr>
</tbody>
</table>

### MIPS Year 2 (2018)

#### Additional Activities

### MIPS Year 2 (2018)

#### Scoring

<table>
<thead>
<tr>
<th>Scoring</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are finalizing additional activities, and changes to existing activities for the Improvement Activities category including a score for using appropriate PAS toCog® and a qualified clinical support mechanism for all advanced diagnostic imaging services rendered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For virtual group reporting, only one MIPS eligible clinician in a virtual group must perform the Improvement Activity for the TIN to receive credit</td>
</tr>
<tr>
<td></td>
<td>For group reporting, only one MIPS eligible clinician in a TIN must perform the Improvement Activity for the TIN to receive credit</td>
</tr>
<tr>
<td></td>
<td>To allow simple attestation of Improvement Activities, the highest score</td>
</tr>
</tbody>
</table>

---

#### Notes

- **New deadline of December 31** of the performance year for the submission of hardship exception applications for 2017 and 2018 year MIPS eligible clinicians |
- **Reweighting through an approved application**: The following Advanced Clinical Quality Measures (for 15 or fewer clinicians) will be reweighted through an approved application: Advance Directives, Avoidable Hospitalization, Participation in Post-Acute Care, and Preventive Clinical Measures (including measure based on the CPEX measure set) |
- **New measures of December 31** of the performance year for the submission of hardship exception applications for 2017 and 2018 year MIPS eligible clinicians |
- **New measures of December 31** of the performance year for the submission of hardship exception applications for 2017 and 2018 year MIPS eligible clinicians |
- **Reweighting through an approved application**: The following Advanced Clinical Quality Measures (for 15 or fewer clinicians) will be reweighted through an approved application: Advance Directives, Avoidable Hospitalization, Participation in Post-Acute Care, and Preventive Clinical Measures (including measure based on the CPEX measure set)
MIPS Year 2 (2018)
Performance Threshold and Payment Adjustment

Change: Increase in Performance Threshold and Payment Adjustment


How can I achieve 15 points?

• Report all required Improvement Activities.
• Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
• Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
• Submit 6 Quality measures that meet data completeness criteria.

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

MIPS Year 2 (2018)
MIPS: Performance Threshold & Payment Adjustment

Final Score 2017 Payment Adjustment 2019
>70 points
• Positive adjustment
• Eligible for exceptional performance bonus—minimum of additional 0.5%

4-69 points
• Positive adjustment
• Not eligible for exceptional performance bonus

3 points
• Neutral payment adjustment

0 points
• Negative payment adjustment of -4%
• 0 points = does not participate

Final Score 2018 Change Y/N Payment Adjustment 2020
>70 points N
• Positive adjustment greater than 0%
• Eligible for exceptional performance bonus—minimum of additional 0.5%

15.01-69.99 points Y
• Positive adjustment greater than 0%
• Not eligible for exceptional performance bonus

15 points Y
• Neutral payment adjustment

3.76-14.99 Y
• Negative payment adjustment greater than -5%
• Negative payment adjustment of -5%

0-3.75 Y
• Negative payment adjustment of -5%

MIPS Year 2 (2018)
Scoring

• Up to 5 bonus points available for treating complex patients based on medical complexity.
  - As measured by Hierarchical Condition Category (HCC) risk score and a score based on the percentage of dual eligible beneficiaries.
  - MIPS eligible clinicians or groups must submit data on at least 1 performance category in an applicable performance period to earn the bonus.

MIPS Year 2 (2018)
Complex Patient Bonus

MIPS Year 2 (2018)
Small Practice Bonus

• 5 bonus points added to the final score of any MIPS eligible clinician or group who is in a small practice (15 or fewer clinicians), so long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period.

• Burden Reduction Aim:
  - We recognize the challenges of small practices and will provide a 5 point bonus to help them successfully meet MIPS requirements.
### What you know:

- Facility-based measurement assesses clinicians in the context of the facilities at which they work to better measure their quality.
- Voluntary facility-based scoring mechanisms will be aligned with the Hospital Value Based Purchasing Program (Hospital VBP) to help reduce burden for clinicians.
- Eligible as individual: You must have 75% of services in the inpatient hospital or emergency room.
- Eligible group: 75% of eligible clinicians must meet eligibility criteria as individuals.
- Measures will be based on Hospital VBP for quality and cost measures.
- Scores will be derived using the data at the facility where the clinician treats the highest number of Medicare beneficiaries.
- The facility-based measurement option converts a hospital Total Performance Score in a MIPS quality performance category and cost performance category score.

### MIPS Year 2 (2018)

**Facility-based Measurement**

- To make it easier for clinicians to search and find information on the Quality Payment Program, CMS has moved its library of QPP resources to CMS.gov
- QPP.CMS.GOV redirects to the CMS.GOV Resource Library:
  - Final Rule Materials Posted: [https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html](https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html)

### Resource Library Update


### Technical Assistance

**Available Resources**

CMS has free measures and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

**The Basic Science of Health Measurement**

Rikki Mangrum, MLS
Senior Researcher, Research and Evaluation
American Institute for Research

### Available Resources

CMS has free measures and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

**The Basic Science of Health Measurement**

Rikki Mangrum, MLS
Senior Researcher, Research and Evaluation
American Institute for Research

### What are you measuring?

**The**...
- Rate
- Volume
- Quality
- Performance

**Of a...**
- Person
- Place
- Thing

### Quality and Performance Measures

**There needs to be a responsible entity that**
- Can be identified
- Can be accountable for its behavior
- Has sufficient control over what is being measured

**The measurement itself is**
- Rigorous
- Systematic
- Quantifiable
### Four core scientific criteria for measures

**Importance**
- Measures something that matters to clinicians and patients
- Health care can make a difference in what is being measured

**Validity and Reliability**
- **Validity** = Accurate
  - Measures what it is supposed to measure
  - Produces accurate, credible results that represent what happens in a population, including its variations
- **Reliability** = Precise
  - Definable, repeatable
  - Measures produce consistent, reproducible results under the same conditions

### Four core scientific criteria for measures, cont’d

**Feasibility**
- There is a way to capture data for it
- It is not highly complicated or expensive to do

**Validity and Reliability**
- People can make sense of the measure and use it in some productive way
- Facilities accountability and/or transparency

### Additional guidance and requirements may apply…

**eCQMs**
- Electronic clinical quality measures using EHRs undergo testing to ensure that the export, import, calculate, and report features of eCQMs function as intended in certified health IT systems

**Patient-reported outcome measures**
- Specific forms of evidence are required for importance and content validity
- Psychometric testing
- Proxy measures, where someone reports on behalf of the patient, are still controversial

### Professional Societies Make Measures and get Them Endorsed

- American College of Cardiology
- American Nurses Association
- Renal Physicians Association
- Society of Thoracic Surgeons

### Approaches to Measure Development

**Adapt an existing measure**
- Change the scope → add or remove types of patients
- Change the data source → adapt measure for a different type of facility
- Risk adjustment → add or remove types of risks, such as comorbidities
- May be faster and less expensive, but not necessarily

**Develop a new measure**
- Begin with a measure concept that is discrete and definable
- Validate it through pilot and field testing
- Can be time-consuming and expensive, but not necessarily

### What are the steps?

**1. Develop a concept**
- Review literature and engage with experts, clinicians, patients/family, and payers to document the importance of the measure
- Document any evidence for an existing measure OR demonstrate a gap
  - Measure harmonization and limiting the proliferation of measures are important goals
- But, that doesn’t mean we should use inappropriate measures
- For CMS: Develop a rationale or business case: why will this measure make a difference in terms of cost, value, or patient safety?
### What are the steps?

#### 2. Specify the measure
- Clearly define the measure concept in concrete terms
  - What are the numerator and the denominator?
  - Where does the data come from?
  - What is the calculation?
- Get comment from a wider audience of experts, clinicians, patients/family, payers
  - How is this measure going to be useful?
  - How can it be improved?
- Feasibility testing at this stage is usually critical
  - Can people actually collect the proposed data and execute the calculation?
  - If not, can any obstacles be addressed?

#### 3. Test the measure
- Determine if the measure can be used as intended
  - Is the data of sufficient quality and consistency?
  - Do algorithms or other reporting functions work properly across entities?
- Determine if the measure can support the evaluation of quality as intended
  - Accurately captures variation?
  - Results are usable, actionable?
- Revise the measure if needed and re-test

#### 4. Develop a measure implementation plan
- Create guidance for people who will implement the measure
  - What do people have to do
  - How do they do it
  - Who should do what
- Include direct and indirect cost considerations
  - System modifications
  - Staff time

#### 5. Monitor and sustain the measure
- Periodically re-evaluate to assess whether the measure is
  - Important and usable
  - Working as intended
  - In need of improvement
- Seek and maintain measure endorsement from NQF