



The Future of BIGDATA in MIPS, APMs and MACRA

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About Jennifer

Jennifer Searfoss, Esq., CPOM, CHCI, CMCS

is the CEO of the Searfoss Consulting Group, LLC since its founding in 2011 and is focused on value improvement, revenue cycle management and strategic planning in this post-health reform world.

Jennifer was the Vice President of External Provider Relations for UnitedHealthcare, a Minnesota-based health insurance company. From 2007 to April 2011, she established and led the Provider Communications & Advocacy unit. Before going behind the iron curtain, Jennifer served as the External Relations Liaison for the Washington, DC-based Government Affairs Department of the Medical Group Management Association.





In accordance with the Accreditation Council for Continuing Medical Education's Standards for Commercial Support I publicly declare that:

I have direct financial control or relevant relationships over any of the healthcare products or services now or in the past 12 months:

- I am the majority owner of SCG Health
- SCG Health is a vendor in the AOA Member Value Program



Do you remember why you went into
healthcare?

Reflect.

Remember that reason and hold onto it. You will
need it during the chaos.

Inspire.

Find stories of colleagues that inspire you to do
great patient care. And inspire others.



Institute for Healthcare Improvement **Triple Aim**

Simultaneous pursuit of three aims



Improving the experience of care



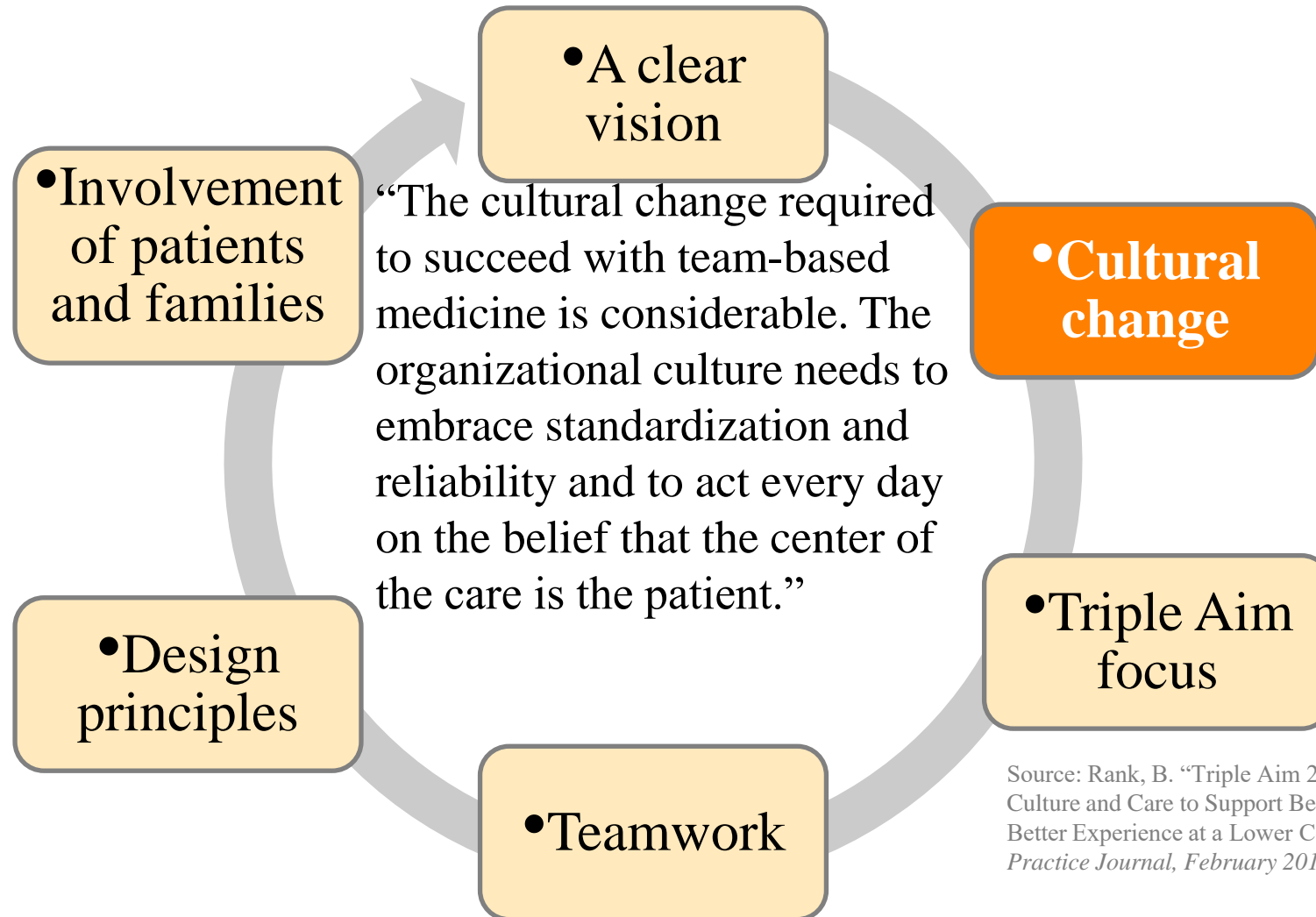
Improving the health of populations



Reducing per capita costs of healthcare



Inspiring dramatic cultural change



Source: Rank, B. “Triple Aim 2.0: Designing Culture and Care to Support Better Health, Better Experience at a Lower Cost.” *Group Practice Journal*, February 2013.



Care coordination opportunities





Eligible ~~Providers~~ Eligible Clinicians

Check your participation status

Enter your National Provider Identifier (NPI) number

NPI Number

Check NPI >



Eligible Clinicians (ECs)

- Physicians
- Physician's Assistant
- Nurse Practitioner
- Clinical Nurse Anesthetist
- Clinical Nurse Specialist



Ineligible Exempt Clinicians

- 2017-2018 examples
- Physical Therapists
- Occupational Therapists
- Certified Nurse Midwife



2018 Low Volume Clinicians

- Medicare Part B allowed charges \leq \$90,000
OR
- Care for \leq 200 Part B Medicare patients



Congress & cost Bipartisan Budget Act of 2018

MIPS payment
adjustments apply only to
covered *professional
services* paid under MPFS

- Advocated by the oncology community (Part B drugs)
- Rule: Low volume threshold **ONLY** on allowed charges (and volume) for covered professional services

Cap the Cost Category at
max 30% of MIPS weight

- 2018 final rule proposed weight of 30%
- Rule: 15% of MIPS weight



2019 MPFS NPRM & Final Rule QPP Year 3

NPRM Released on July 12, 2018

- Published in the Federal Register on July 27, 2018

Final rule released on or about November 1, 2018

- Due to election, anticipate release after November 6 – **but released on November 1!!!**

Certain items, such as the Registry/QCDR changes, were nearly final as proposed because the 2019 Self-Nomination Period closed November 1, 2018.

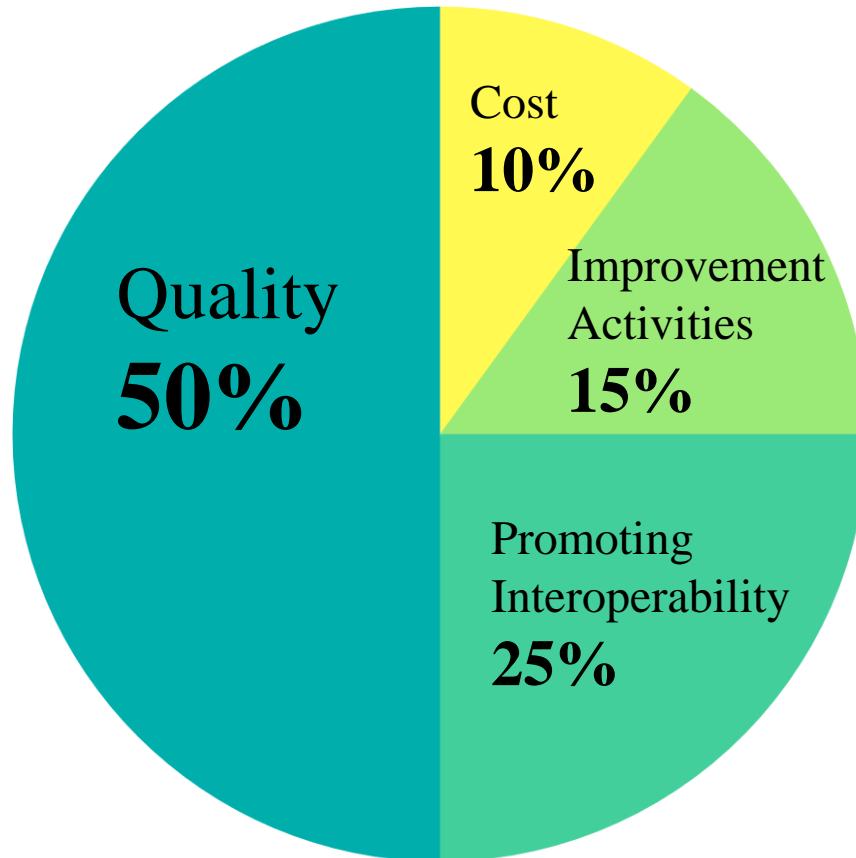
QPP items begin on page 875 of 2378 page “pre-publication version.” Official version will appear in Federal Register on November 23.



MIPS Category Weights

2018 MIPS Weights

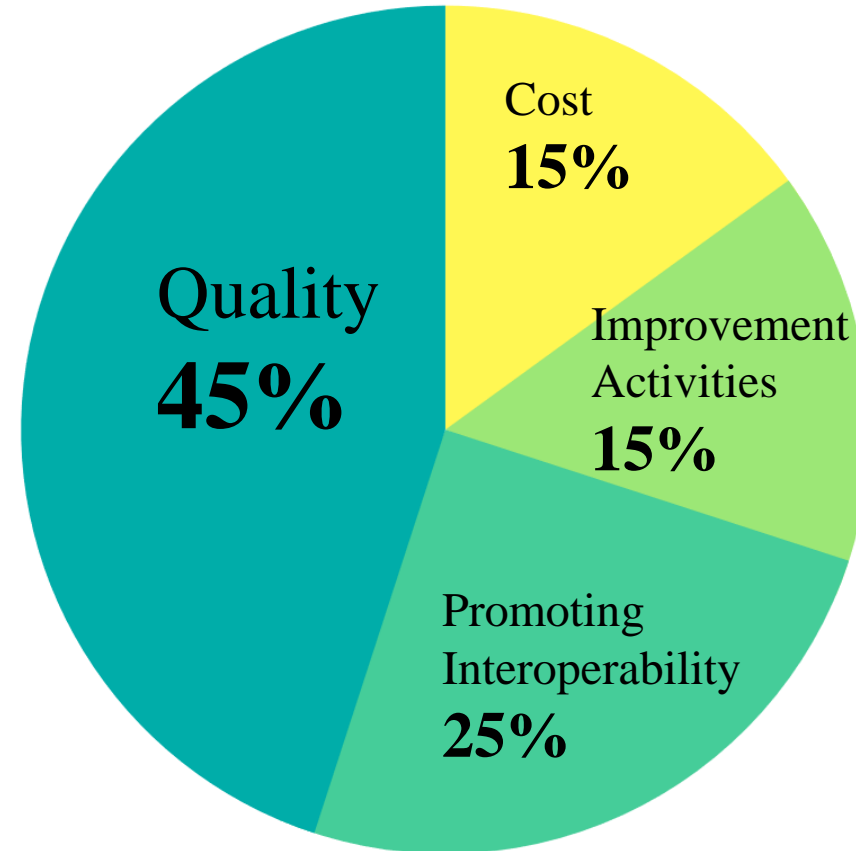
Mitigate 5% cut = 15 points
in 2 categories



Exceptional Performers: 70 points

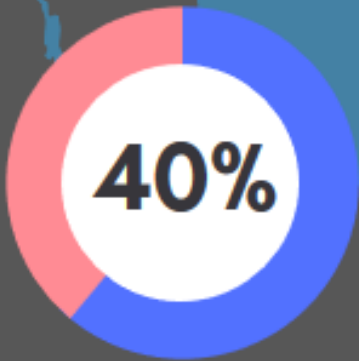
2019 MIPS Weights

Mitigate 7% cut = 30 points
in 2 categories

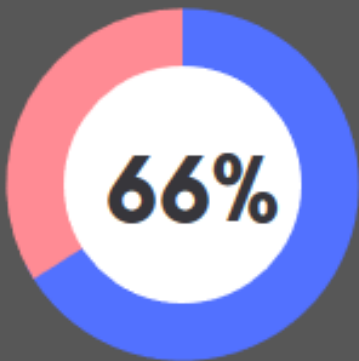


Exceptional Performers: 75 points

2018 MACRA PARTICIPATION STATISTICS



MEDICARE PART B CLINICIANS THAT MUST PARTICIPATE UNDER MACRA



MEDICARE RECEIPTS COVERED UNDER A MACRA PROGRAM



MIPS PARTICIPATION CHANGES

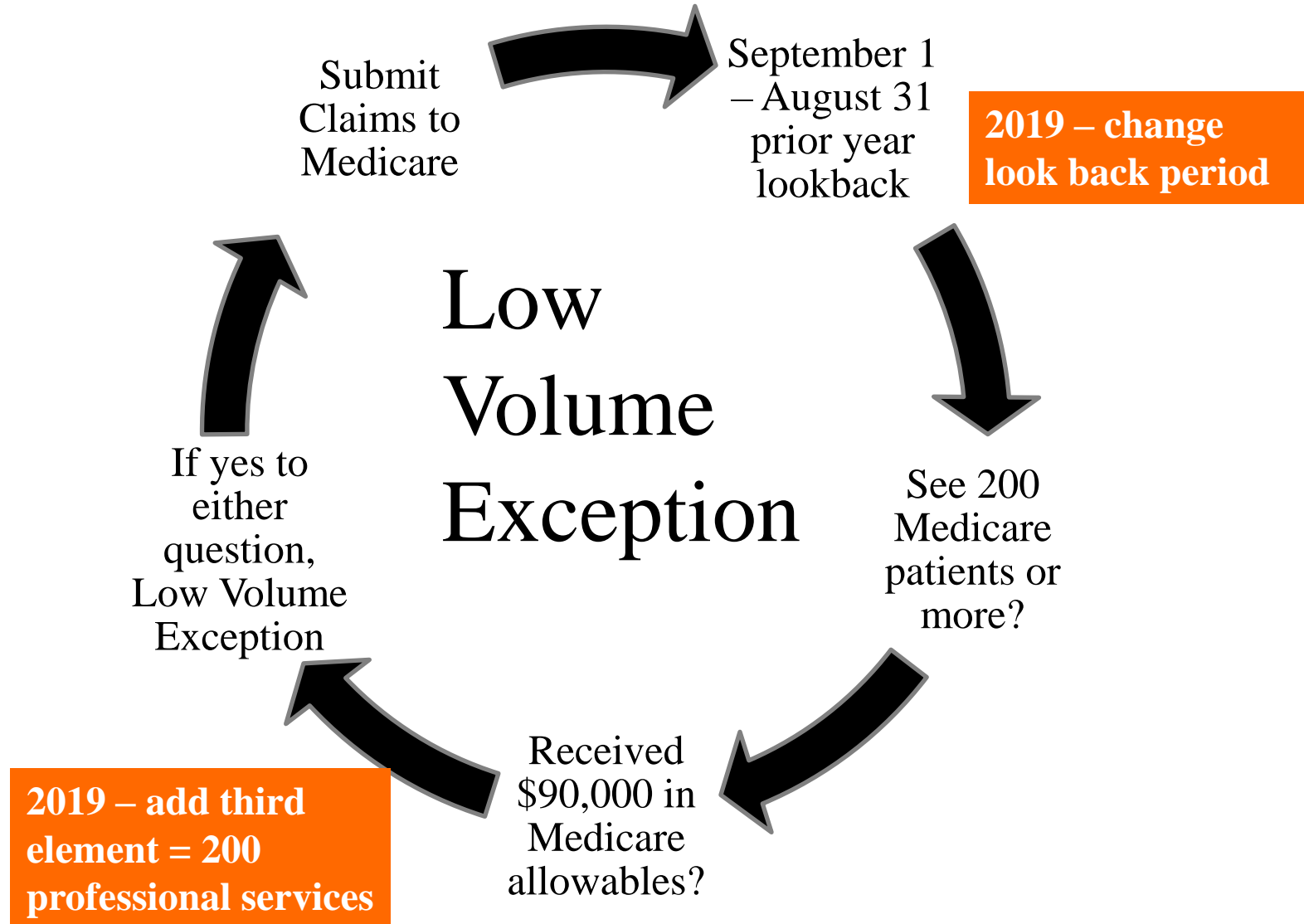


2018 EXEMPTION VOLUME



- The tests are an either OR. Not an AND.
- Lookback for 2018 is was two periods:
 - September 1 – August 31, 2017
 - September 1 – August 31, 2018
- If qualify during either period, clinician exempt

Low Volume Exception - 2018



2018 EXEMPTION VOLUME

34.91%



LOW VOLUME EXCLUSION



Participation Lookup - 2018

- Letters were/will be sent out to clinicians by the MACs
 - Ineligible exempt clinicians are not addressed in the notices
- Lookup at <https://qpp.cms.gov/participation-lookup>
- Latest period lookback will be posted in November
- Take screenshots with the datestamp to prove low volume exclusion

QPP Participation Status

Enter your 10-digit [National Provider Identifier \(NPI\)](#) [↗](#) number to view your QPP participation status by performance year (PY).

QPP Participation Status includes APM Participation as well as MIPS Participation.

Please note that the QPP Participation Status Tool is only a technical resource and is not dispositive of any eligible clinician's, group's, or organization's status under QPP. For more information, please refer to the Quality Payment Program regulations at 42 C.F.R. part 414 subpart O.

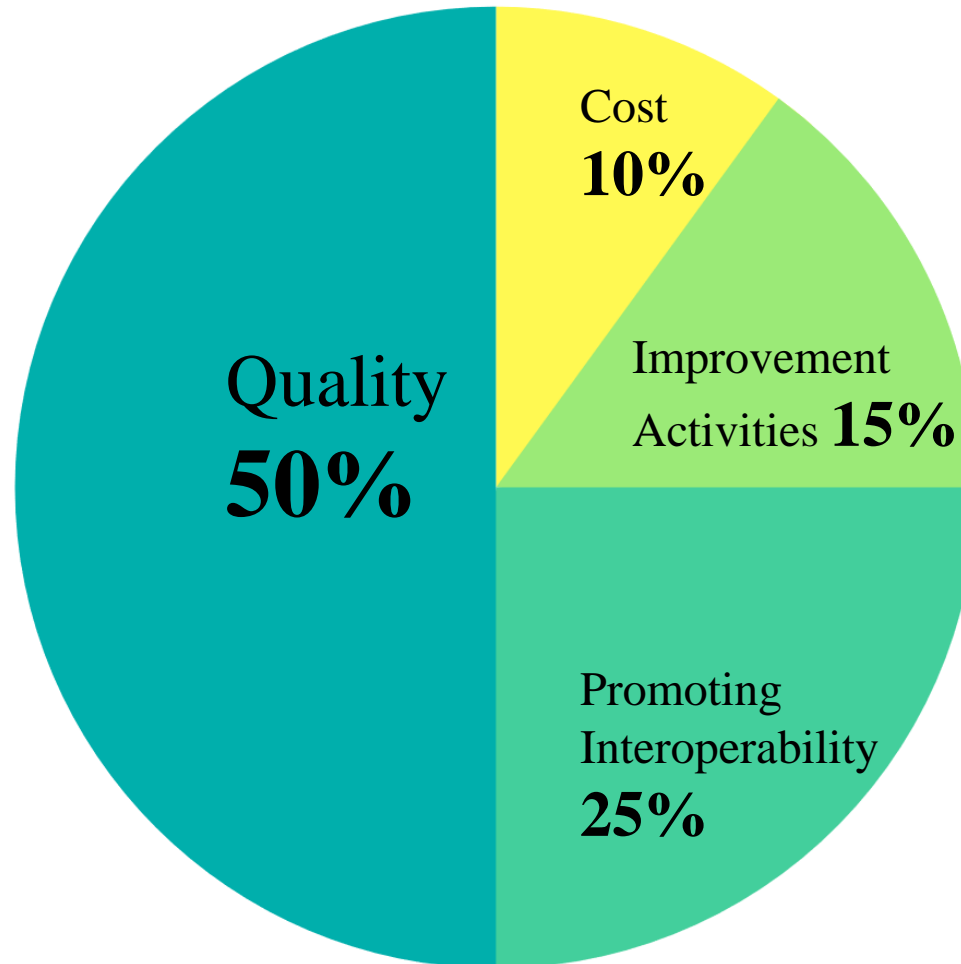
MIPS	APMs	About	Sign In
Merit-based Incentive Payment System	Alternative Payment Models	The Quality Payment Program	Submit and Manage Data

PARTICIPATION	MEASURES
MIPS Overview	Quality Measures Requirements
Individual or Group Participation	Promoting Interoperability Requirements
About MIPS Participation	Improvement Activities Requirements
Exception Applications	Cost Measures Requirements
How to Register for CMS Web Interface and CAHPS for MIPS Survey	

[Check Participation Status](#) [Explore Measures](#)



2018 MIPS Categories



Quality *formerly PQRS*

Report six MIPS or non-MIPS Measures for 50% or more of your patient population

- Claims-based; Registry; QCDR; EHR; Web Interface

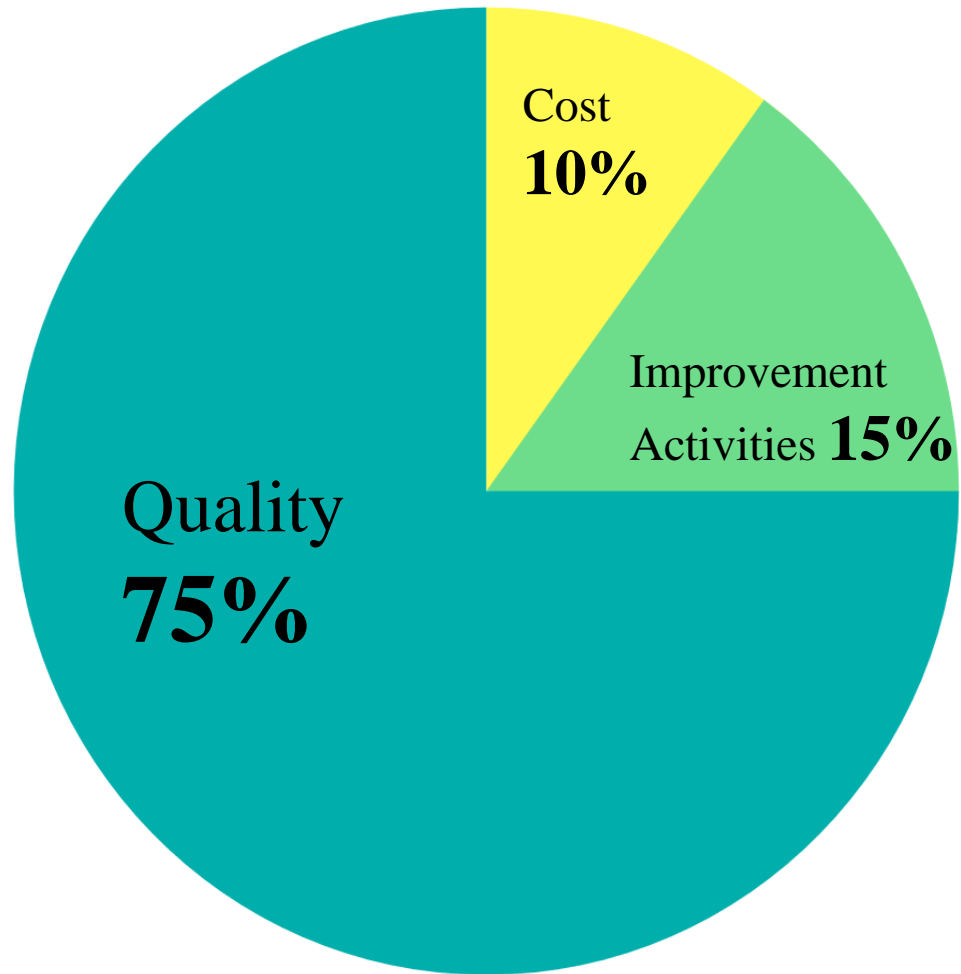
Promoting Interoperability (PI) *formerly Meaningful Use and Advancing Care Information.* Four base required objectives. Optional objectives too.

Improvement Activities (IA) Attestation to performing activities to improve quality and decrease cost.

Cost *formerly VBM*
Calculated by CMS for patients attributed to your TIN.



Alt. 2018 MIPS Weights



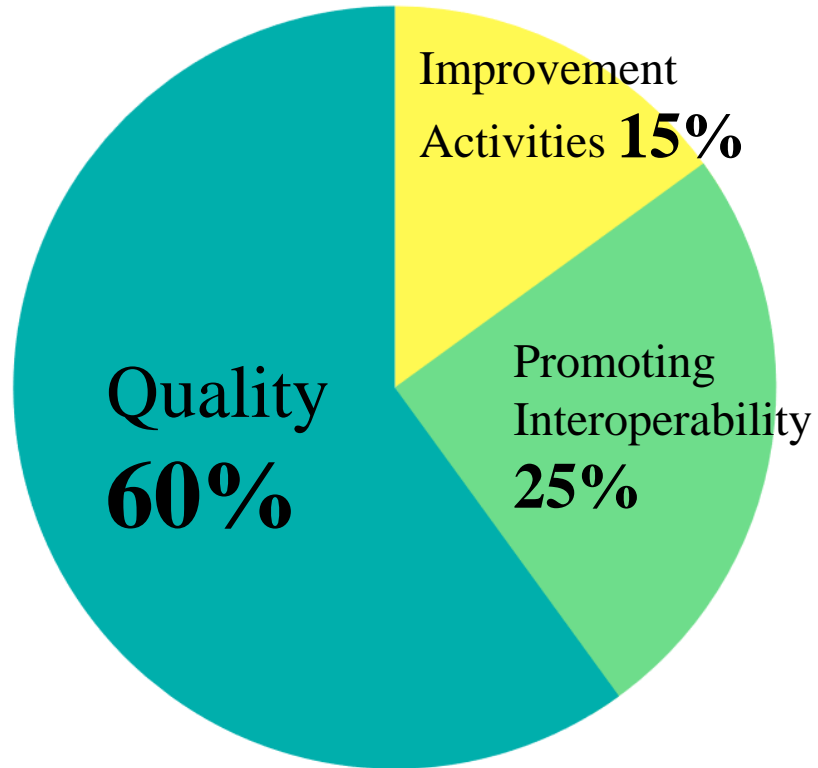
Certain MIPS eligible clinicians qualify for an automatic reweighting:

- Hospital-based MIPS clinicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinicians who lack face-to-face interactions with patient



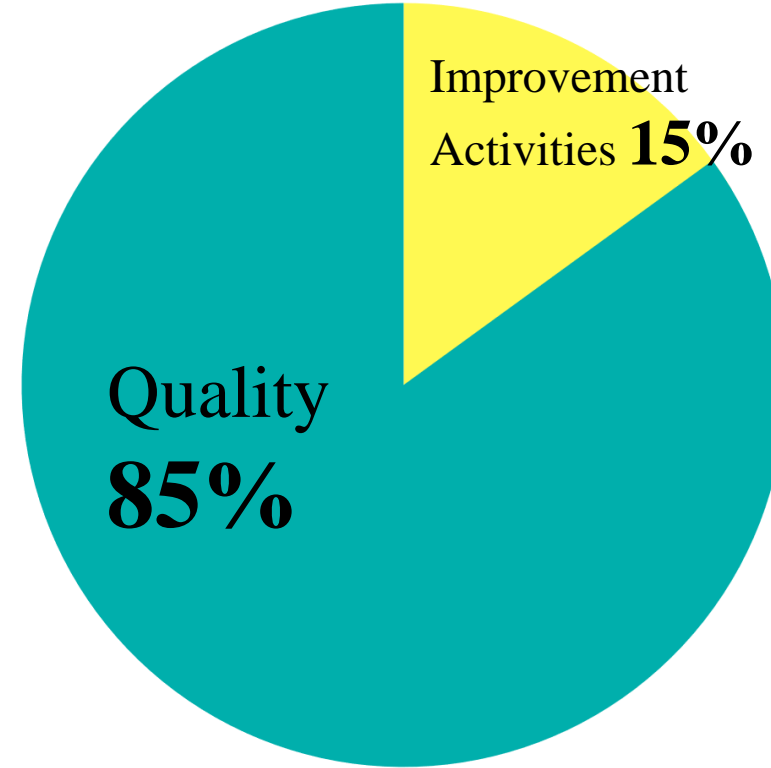
Alt. 2018 MIPS Weights

No E/M services



No E/M services

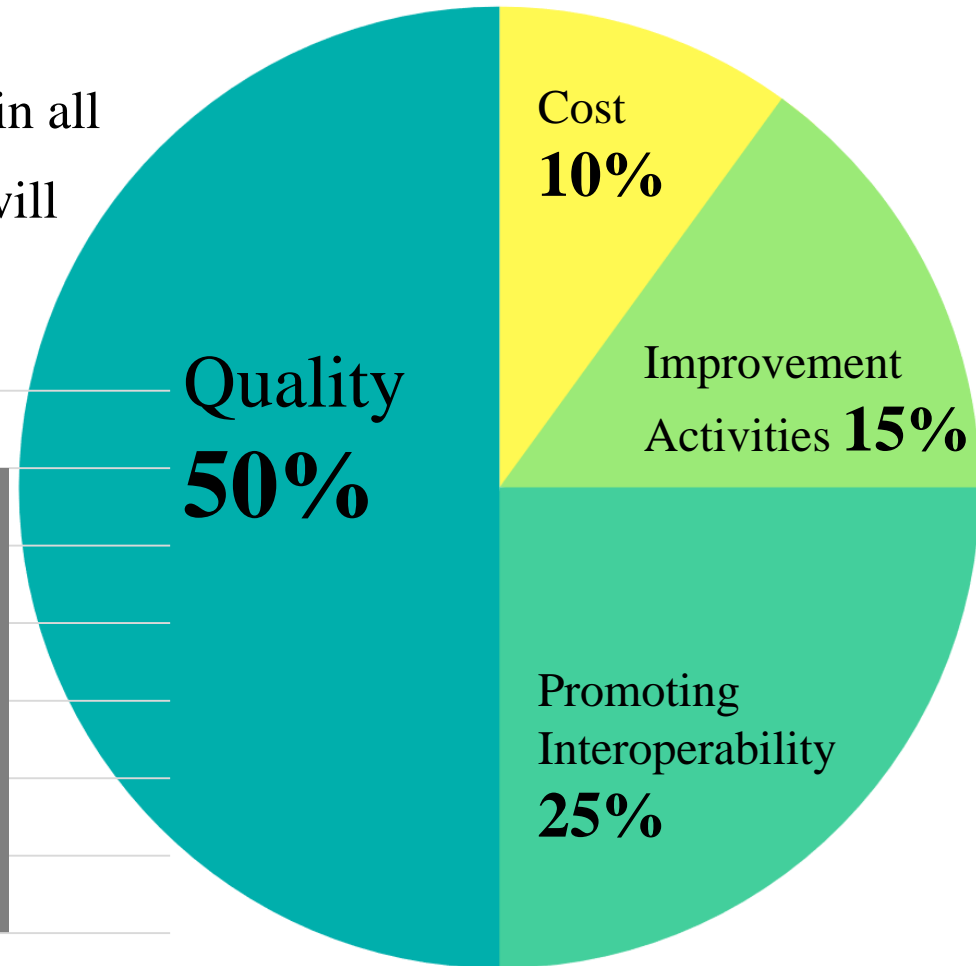
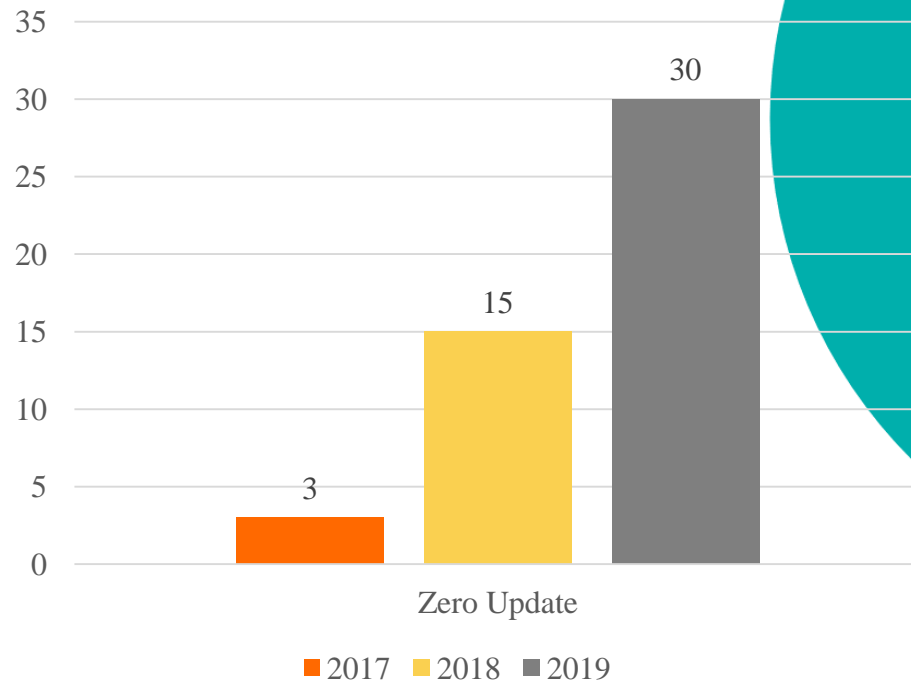
Automatic PI reweighting





2018 Scoring Thresholds - Minimum

Improvement Activities alone in all alternative weighting models will achieve a 0% update.

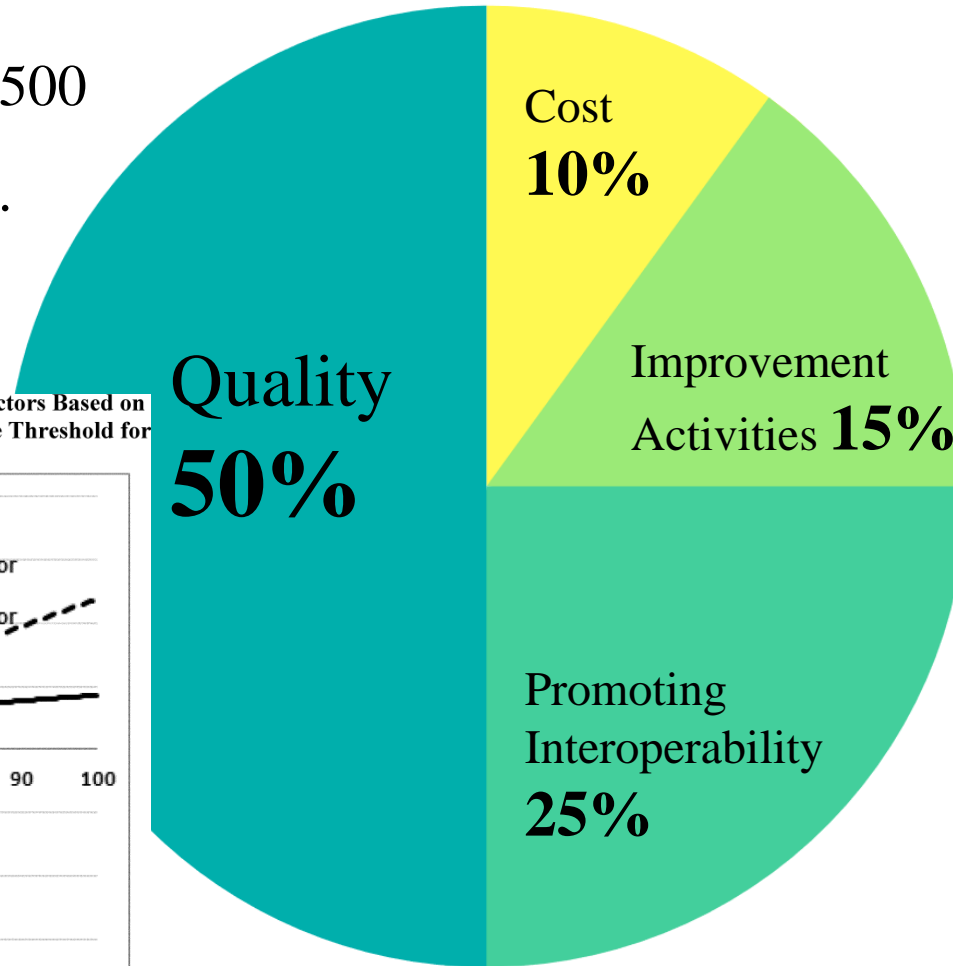
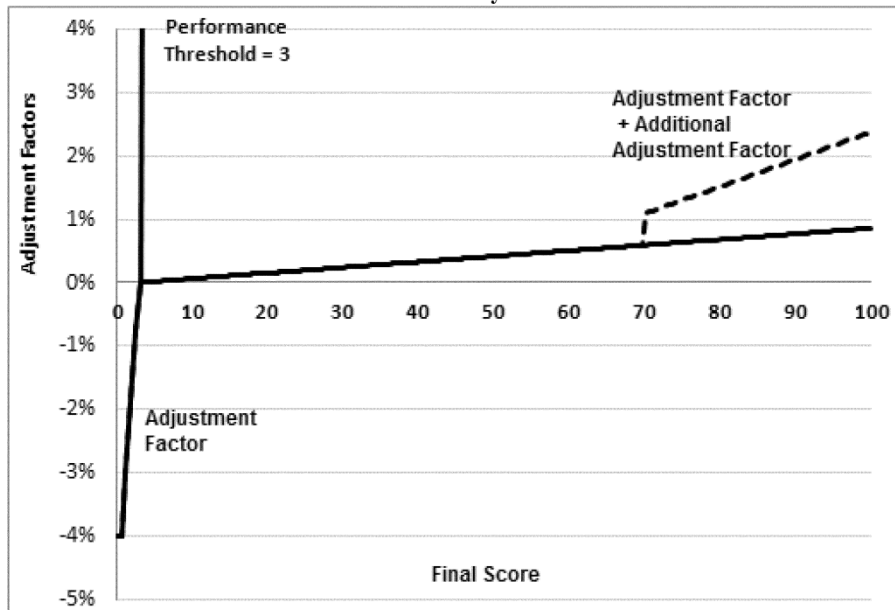




Scoring Thresholds – Exceptional Performer

Congressional set aside of \$500 million kicks in at 70 points.

FIGURE A: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Final Performance Threshold and Additional Performance Threshold for the 2019 MIPS Payment Year





Reporting Methods

Category	Availability	Reporting Method
Quality	January each year	Claims-based; Registry; QCDR; EMR; CMS Web Interface
Promoting Interoperability	Vender specific	Registry; QCDR; EMR; QPP Portal
Improvement Activities	Immediately	Registry; QCDR; EMR; QPP Portal
Cost	After reporting period!	CMS calculates


Registry and QCDR lists posted to [QPP.CMS.GOV](https://www.cms.gov/qpp).

MIPS measures are posted under About > Resource Library.
Non-MIPS measures for QCDRs included in QCDR listing under
Documents & Downloads.




Responsibilities of Registry/QCDR/EMR vendors

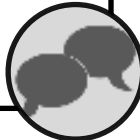
- Registries/QCDRs are required to provide **FOUR** or more reports each year

Feedback 


- Vendors should provide info on current benchmarks and scoring

Bench-marks 


- Vendors should be available to provide guidance on how to improve scores

Guidance 

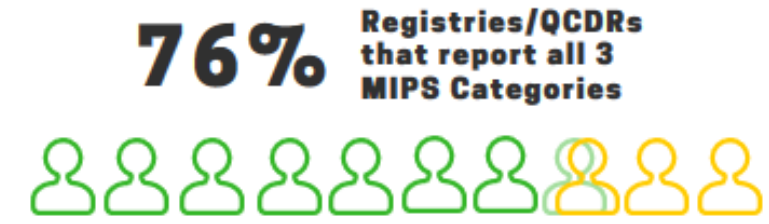
- Vendors send data to CMS in Agency's format (JSON/XML)

Clearing-house 

- Vendors have PHI
- Must have a HIPAA BAA in place

HIPAA 

QPP VENDOR STATISTICS



2018 Qualified Registries **138**

2018 Qualified Clinical Data Registries **146**

2018 Qualified Registries on Probation **5**



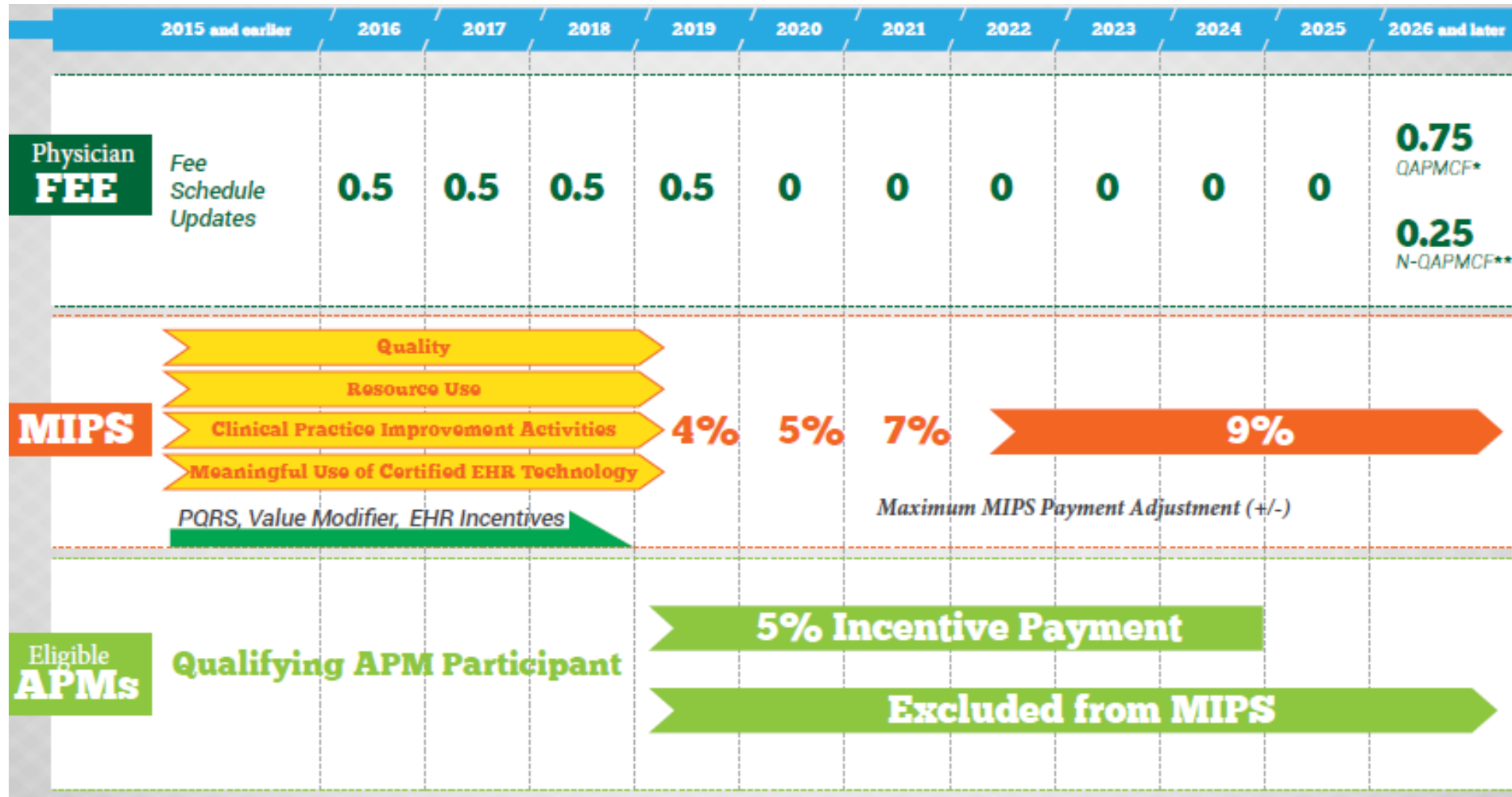
18% Increase in new Registries/QCDRs between 2017-2018

2% Registries/QCDRs withdrawn in 2018



Reimbursement Reform Timeline

Two tracks: MIPS & aAPMs





Not changing: RBRVS reimbursement formula

Resource Based Relative Value Scale (RBRVS)

Payment =

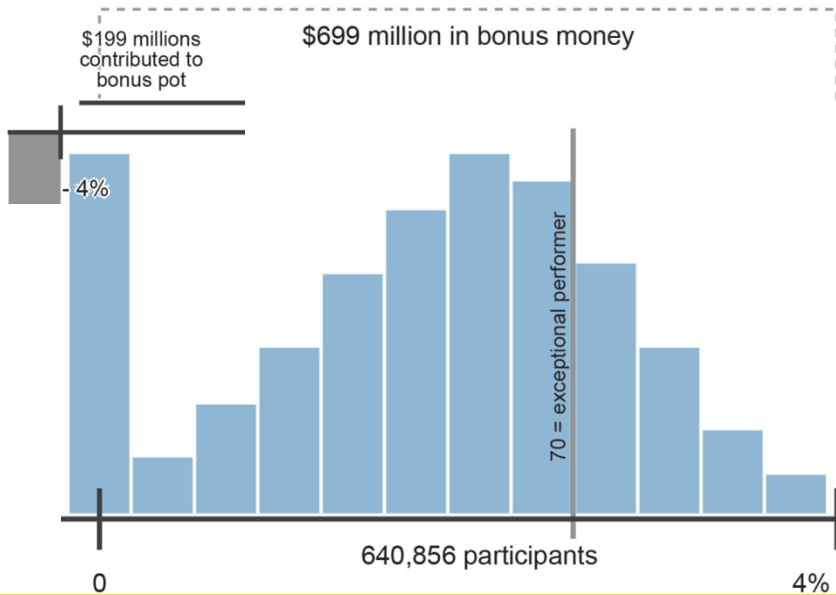
$$\left(\begin{array}{l} \{(\text{RVU work} \times \text{GPCI work}) + \\ (\text{RVU practice expense} \times \text{GPCI} \\ \text{practice expense}) + (\text{RVU} \\ \text{malpractice} \times \text{GPCI malpractice})\} \end{array} \right) \times \begin{array}{l} \text{conversion} \\ \text{factor} \end{array} \times \begin{array}{l} \text{Sequester} \\ \text{cut} \\ \text{MACRA} \\ \text{update} \end{array}$$

RVU = Relative Value Unit

GPCI = Geographic Practice Cost Indices

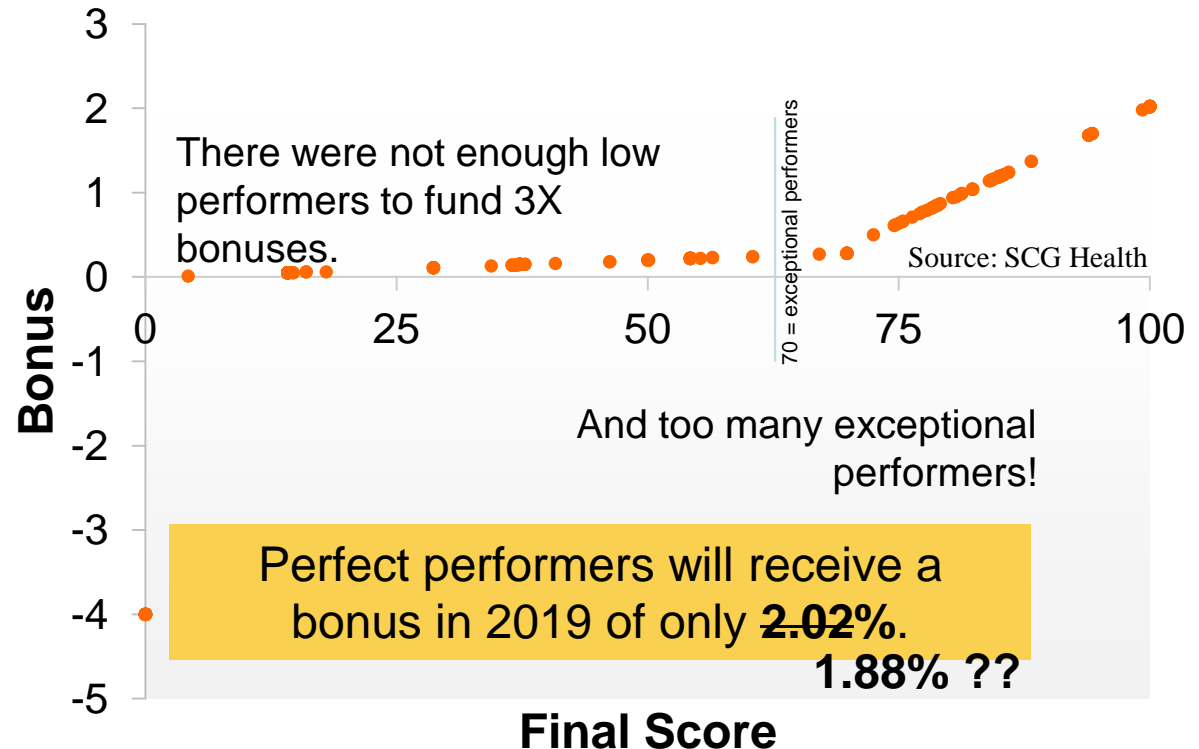


2017 Data | 2019 MIPS Payment Adjustment Expectations vs. Reality



We expected an even distribution of performance such that there could be exceptional performers with more money (\$700 million) for bonuses. Average adjustment was expected to be 0.6% for all eligible clinicians.

Due to the volume of “targeted reviews” – more money was needed to pay performance bonuses. Thus, ALL 2019 bonuses have been reduced. Further adjustment may be necessary.





What this means for your financial future

Medical inflation (medical economic index) = 2.0% annually

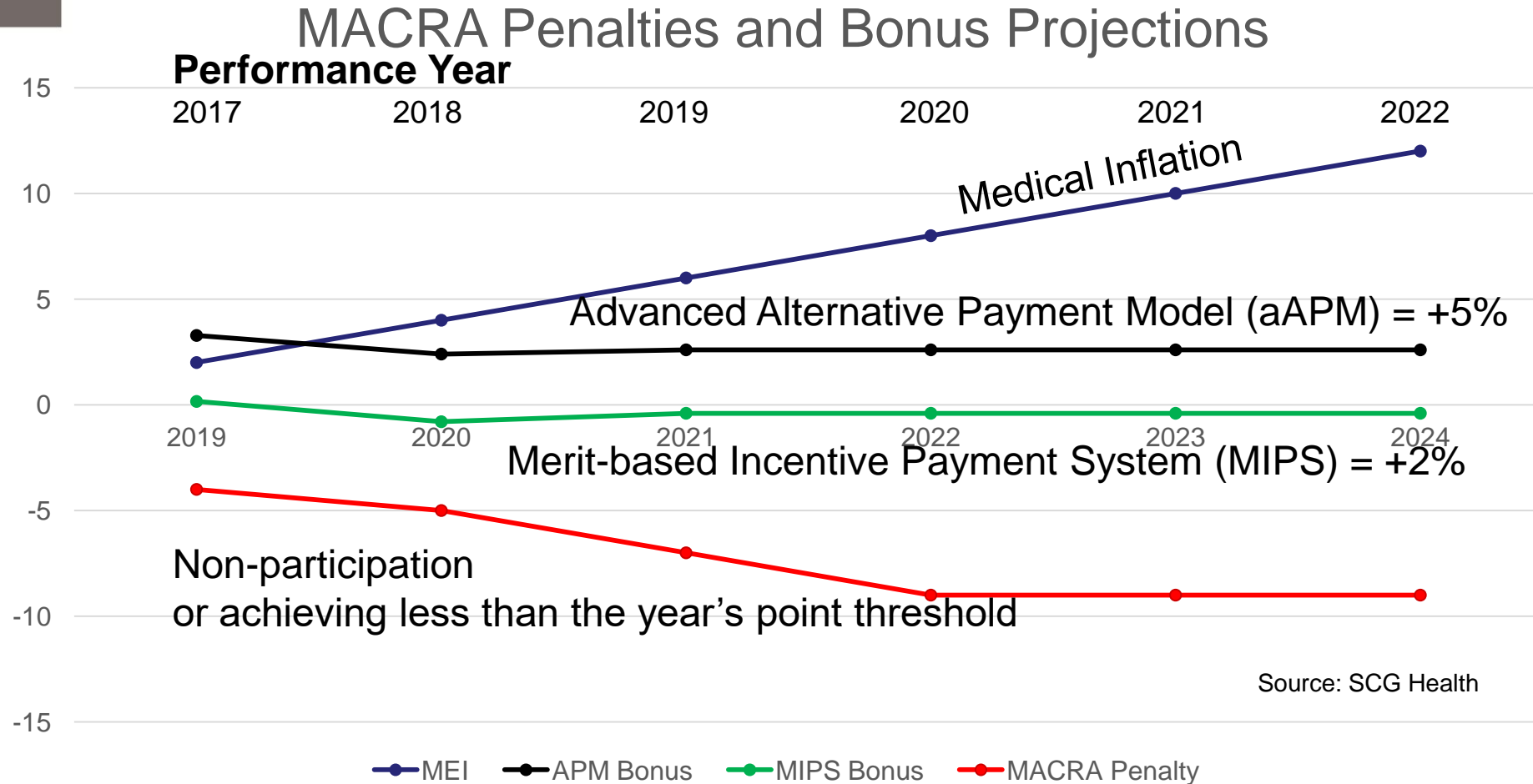
Performance Year	2017	2018	2019	2020
Payment Year	2019	2020	2021	2022
Market Basket Updates	+0.5%	0	0	0
Medicare Adjustment Budget Neutrality	-0.03% *	<u>-0.4%</u> †	<u>-0.4%</u> †	<u>-0.4%</u> †
Medicare Adjustment Mis-valued code target recapture	-0.19% *	<u>-0.2%</u> †	-	-
Sequester	-2%	-2%	-2%	-2%
MIPS Penalty	-OR- -4%	-5%	-7%	-9%
MIPS Bonus	-OR- +1.88%	<u>+2%</u> †	<u>+2%</u> †	<u>+2%</u> †
aAPM Bonus	+5%	+5%	+5%	+5%

For 2017 on 2019 allowables, best case scenarios are +0.5-0.03-0.19-2+5 = **3.28% update under aAPM**
 +0.5-0.03-0.19-2+1.88= **0.16% update under MIPS**

* From proposed rule. † SCG Health projections.



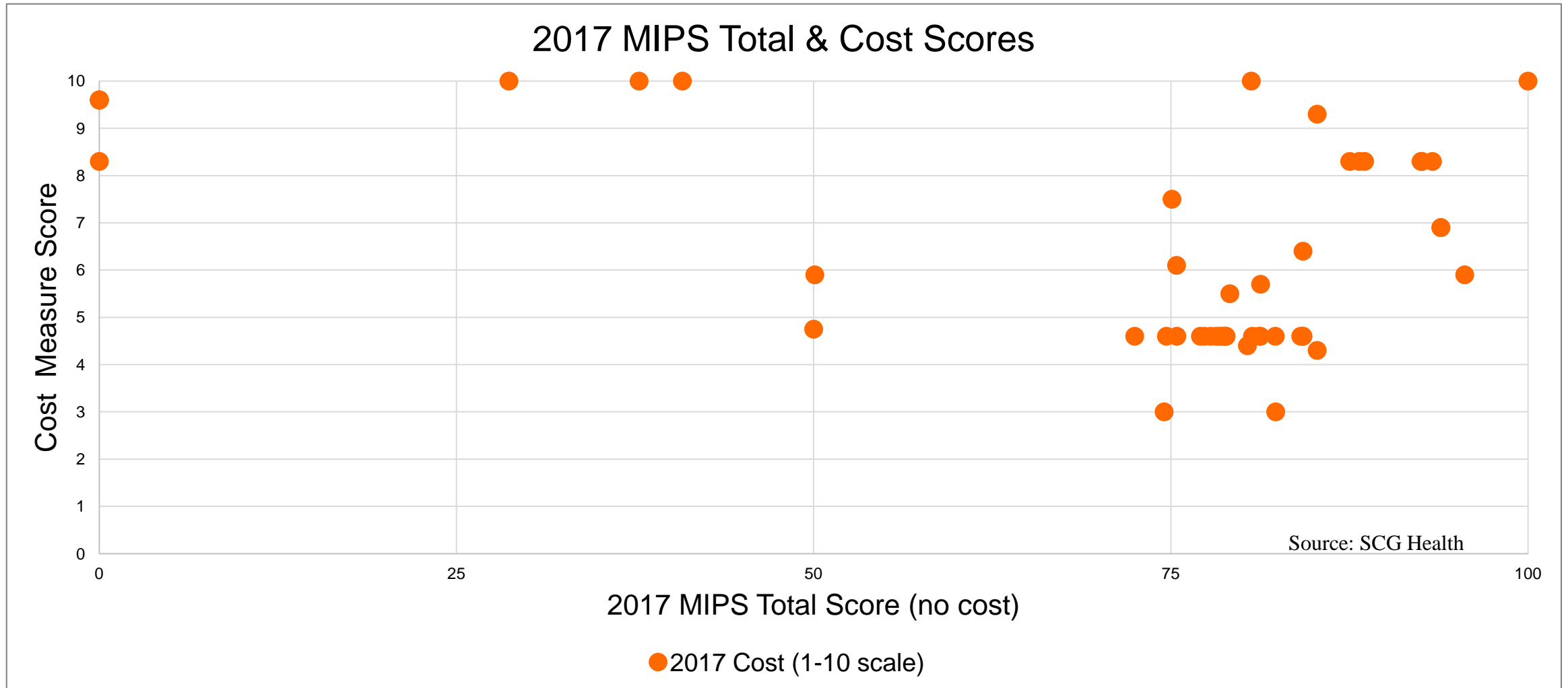
MACRA's Payment Future



Projections include -2% Sequester reduction



Variation means there is an opportunity





Final MPFS for 2019

Promoting Interoperability (MU Stage 3)

HIPAA Security Risk Analysis Attestation remains

See Table 41
Page 115

Only 2015 Edition Certified HIT

e-Prescribing

- +10 eRx
- +5 Query of Prescription Drug Monitoring Program (Yes/No)
- +5 Verify Opioid Treatment Agreement (Yes/No)

Health Information Exchange

- +20 Send Health Information
- +20 Receive and Incorporate Health Information

Provider to Patient Exchange

- +40 Patient Portal Access

Public Health and Clinical Data Exchange

- CHOOSE TWO
- +10 Immunization Registry
- +10 Public Health Registry
- +10 Clinical Data Registry
- +10 Syndromic Surveillance
- +10 Electronic Case Reporting

Clinicians are required to report certain measures from each objective, unless an exclusion is claimed. Information Blocking and ONC Direct Access Attestation remain.

Removes: Patient-Generated Health Data; Patient-Specific Education; Secure Messaging; View, Download + Transmit; Clinical Information Reconciliation



2019 Final Rule Changes



Low Volume Threshold

- 200 patients
- \$90,000 allowables
- *New: 200 covered professional services*
- *New: Opt-in available when not meet all 3*
 - *No sign up required*



New Clinicians & Groups

- Assigned performance threshold (30 points)
- Clinician joins TIN on or after Oct. 1
- TIN formed (first bills Medicare) on or after Oct. 1



Reporting Methods

- Quality Reporting Option Combo
- Data could come in from more than 1 vendor or method
- **Claims-based small GROUP reporting option (2-16 ECs)**
- **Solos can still do claims-based reporting**

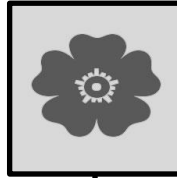


2019 Final Rule Changes



Virtual Groups

- **No changes**
- Lookback period 10/1-9/30 (for all lookbacks)
- Must elect by Dec. 31, 2018!!!



Data Completeness

- No change = 60%
- *New: reporting CAHPS and insufficient sample size = 0 points*



Cost

- *New: 8 episode-based measures added*
- Case minimums
- 10 procedural episode
- 20 acute inpatient episodes
- Cost improvement forthcoming



New measures – Quality Category

MAP ID	Title	MAP Decision	Description
MUC17-139 High Priority	Continuity of Pharmacotherapy for Opioid Use Disorder	Refine and Resubmit Prior to Rulemaking	Adults who had a diagnosis of OUD and at least one claim for an OUD Rx
MUC17-168 Outcome	Average change in functional status following lumbar spine fusion surgery	Support for Rulemaking	Eligible Population: Patients with lumbar spine fusion procedures occurring during a 12 month period for patients age 18 and older at the start of that period. Denominator: Patients within the eligible population whose functional status was measured by the Oswestry Disability Index, version 2.1a (ODI, v2.1a) within three months preoperatively AND at one year (+/- 3 months) postoperatively.
MUC17-169 Outcome	Average change in functional status following total knee replacement surgery	Support for Rulemaking	Patients with total knee replacement procedures occurring during a 12 month period for patients age 18 and older at the start of that period. Denominator: Patients within the eligible population whose functional status was measured by the Oxford Knee Score within three months preoperatively AND at one year (+/- 3 months) postoperatively



New measures – Quality Category

MAP ID	Title	MAP Decision	Description
MUC17-170 Outcome	Average change in functional status following lumbar discectomy laminotomy surgery	Conditional Support for Rulemaking	Patients with lumbar discectomy laminotomy for a diagnosis of disc herniation occurring during a 12 month period for patients age 18 and older at the start of that period. Denominator: Patients within the eligible population whose functional status was measured by the Oswestry Disability Index, version 2.1a (ODI, v2.1a) within 3 months preoperatively AND at three months (6 to 20 weeks) post-op.
MUC17-173 High Priority	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture	Conditional Support for Rulemaking	Female patients ages 50 to 64 years with an encounter during the measurement period
MUC17-177 Outcome	Average change in leg pain following lumbar spine fusion surgery	Conditional Support for Rulemaking	Patients with lumbar spine fusion procedures occurring during a 12 month period for patients age 18 and older at the start of that period. Denominator: Patients within the eligible population whose leg pain was measured by the Visual Analog Scale (VAS) within 3 months pre-op AND at one year (+/- 3 months) post-op.



New measures – Quality Category

MAP ID	Title	MAP Decision	Description
MUC17-234	Ischemic Vascular Disease Use of Aspirin or Anti-platelet Medication	Conditional Support for Rulemaking	The percentage of patients 18-75 years of age who had a diagnosis of ischemic vascular disease (IVD) and were on daily aspirin or anti-platelet medication, unless allowed contraindications or exceptions are present.
MUC17-310	Zoster (Shingles) Vaccination	Conditional Support for Rulemaking	The percentage of patients 60 years of age and older who have a Varicella Zoster (shingles) vaccination
MUC17-367	HIV Screening	Conditional Support for Rulemaking	Percentage of patients 15-65 years of age who have ever been tested for HIV



Highlights of revised measures

Complete Revamp

Retire the following measures:

#154 Falls: Risk Assessment

#155 Falls: Plan of Care

#318 Falls: Screening for Future Fall Risk (eCQM)

New Measure (NQF 0101 endorsed)

Falls: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls

Three strata for proposed new measure.

Strata 1: Screening for Future Fall Risk

Percentage of patients aged 65 years and older who were screened for future fall risk at least once within 12 months

Strata 2: Falls Risk Assessment

Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months

Strata 3: Plan of Care for Falls

Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 month



Introduction to eQCMs

2018 Specifications

eCQI Resource Center

The one-stop shop for the most current resources to support Electronic Clinical Quality Improvement.

eCQMs EP/EC eCQMs EH/CAH eCQMs Tools and Resources eCQI Standards

<https://ecqi.healthit.gov/>

Name	eCQM ID	NQF ID	MIPS ID	Methods	Update
Breast Cancer Screening	CMS125v6	2372	112	Claims; Registry/ QCDR; EHR; Web	
Cervical Cancer Screening	CMS124v6	0032	309	EHR only	Value Set content updated Sept 2017
Closing the Referral Loop: Receipt of Specialist Report	CMS50v6	-	374	Registry/ QCDR; EHR	
Colorectal Cancer Screening	CMS130v6	0034	113	Claims; Registry/ QCDR; EHR; Web	Value Set content updated Sept 2017
Controlling High Blood Pressure	CMS165v6	0018	236	Claims; Registry/ QCDR; EHR; Web	Value Set content updated Sept 2017

Most QDCs are not eCQMs (only 54)

Most EMRs do not support all 54 eCQMs



Highlights of Changes Tobacco Assessment & Counseling

Update Analytics and Submission Criteria from One
Submission Criteria to Three Submission Criteria

CMS138v6 EHR

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Measure Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Three rates are reported:

- a) Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months
- b) **Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention – BENCHMARK APPLIED TO STRATA 2!**
- c) Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user



Highlights of Changes Tobacco Assessment & Counseling

#226 Claims & Registry/QCDR Update Analytics and Submission Criteria from One Submission Criteria to Three Submission Criteria

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Updated Denominator Criteria for Submission Criteria
One Telehealth Modifiers to include 95 and POS 02

Strata 1:

- **Performance Met: G9902:** Patient screened for tobacco use AND identified as a tobacco user
- **Performance Met: G9903:** Patient screened for tobacco use AND identified as a tobacco non-user

Strata 2: BENCHMARK APPLIED TO STRATA 2!

- **Performance Met: G9906:** Patient received tobacco cessation intervention (counseling and/or pharmacotherapy)

Strata 3:

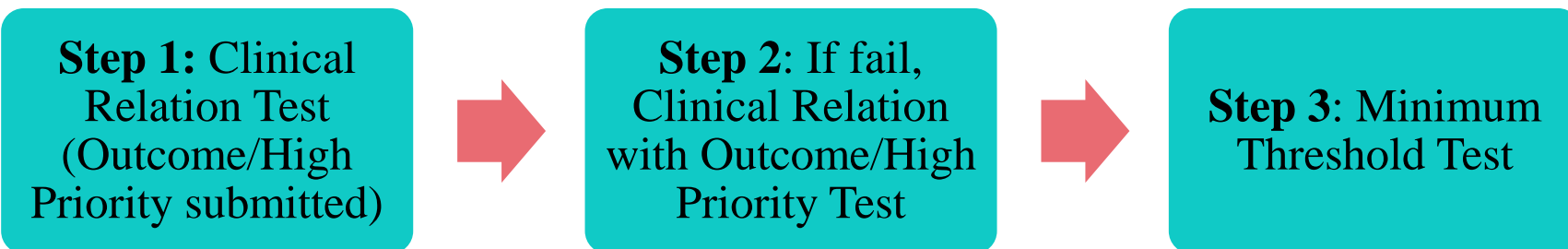
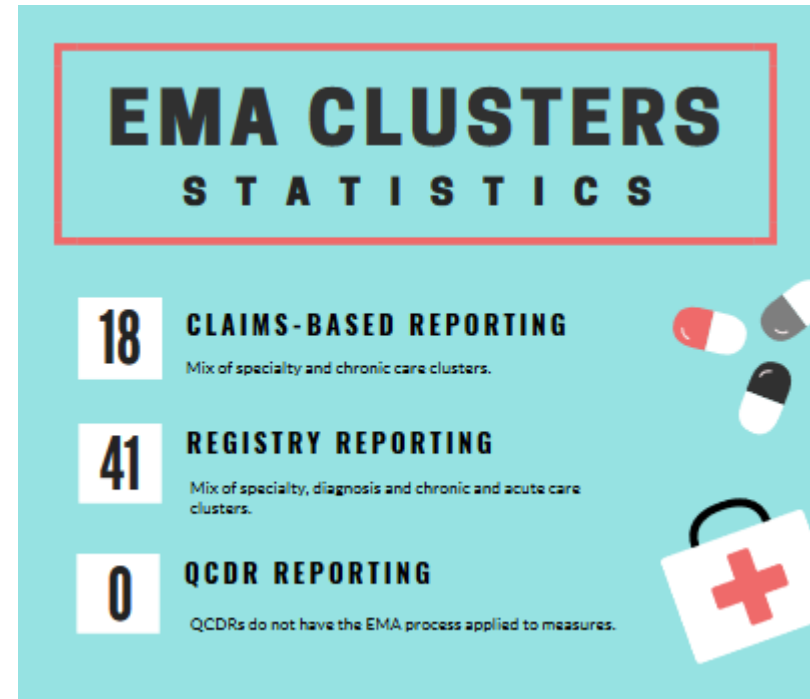
- **Performance Met: 4004F:** Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user
- **Performance Met: 1036F:** Current tobacco non-user



Eligible Measure Applicability (EMA) *formerly MAV*

CMS uses the (EMA) process to see if there are clinically related measures you could have submitted.

- Does not apply if you submit six+ measures with one or more Outcome or High Priority Measure
- Based on what measures you submit
- Not really an issue if you are going for negating the penalty
- If you are going for the exceptional performer bonus, pay attention to EMA!





Example of EMA Cluster for claims-based reporting

Physician submits data for all Medicare patients on #110, #111:

Code	Description	Volume	Unique patients
99203-5	E/M Level New Patients	968	968
99213-5	E/M Level Established Patients	2849	1635



Total patients: 2603 Total encounters: 3817 Data: 100%
Clinical relation: yes measure related **EMA cluster:** 110 + 111 reported together
Minimum threshold: More than 20 patients

Immunization care (claims) cluster measures

#110 Preventive Care and Screening: Influenza Immunization

#111 Pneumococcal Vaccination Status for Older Adults



A closer look at EMA Clusters for claims-based reporting

- #48 Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65+ Years
- #50 Plan of Care for Urinary Incontinence in Women Aged 65+ Years

**Urinary
Incontinence**



- #1 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- #117 **Diabetic Eye Exam***
- #128 BMI Screening and Follow-Up Plan

**Diabetic
Care**



- #130 Documentation of Current Medications in the Medical Record
- #226 Tobacco Use: Screening and Cessation Intervention
- #134 **Screening for Depression and Follow-Up Plan***
- #317 **Screening for High Blood Pressure and Follow-Up Documented***

**General
Care**



* Triggering measures. Not triggered by #1, #128, #130 or #226.



A closer look at EMA Clusters for Registry reporting

- #424 Perioperative Temperature Management
- #426 Checklist for Direct Transfer of Care from Procedure Room to PACU
- #427 Use of Checklist for Direct Transfer of Care from Procedure Room to ICU
- #430 Prevention of Post-Operative Nausea and Vomiting

Anesthesiology
Care



- #126 Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation
- #127 Evaluation of Footwear

Diabetes
Mellitus
Foot Care



- #112 Breast Cancer Screening*
- #113 Colorectal Cancer Screening*
- #130 Documentation of Current Medications in the Medical Record
- #317 Screening for High Blood Pressure and Follow-Up Documented

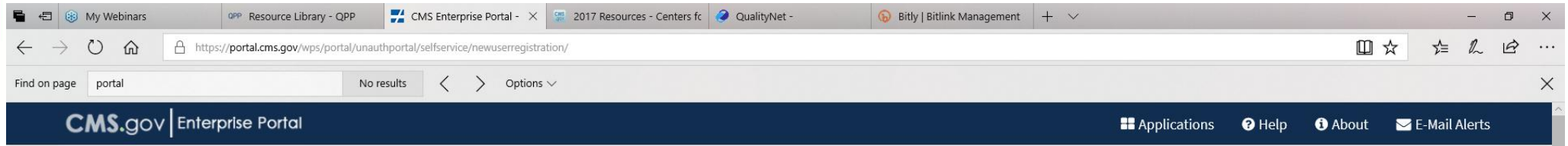
Preventive
Care



* Triggering measures. Not triggered by #130 or #317.



Best Practices



- Screen shots
 - Data Used
 - Submission
- Print everything
 - Electronic
 - Print
- Do it early!
 - Start 1/2/2019!

Step #2: Register Your Information

Step 2 of 3 - Please enter your personal and contact information.

All fields are required unless marked 'Optional'.

Enter First Name Enter Middle Name (optional) Enter Last Name Suffix (optional) ▼

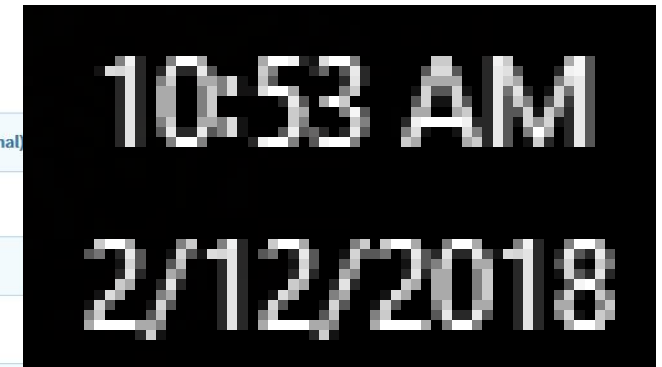
Enter Social Security Number (optional) Birth Month ▼ Birth Date ▼ Birth Year ▼

Is Your Address US Based?

Yes No

Enter Home Address #1 Enter Home Address #2 (optional)

Enter City State ▼ Enter Zip Code





The future of cost under MIPS

Technical Specifications



Episode-based cost measure 2017 field testing

- Elective Outpatient Percutaneous Coronary Intervention (PCI)
- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Routine Cataract Removal with Intraocular Lens (IOL) Implantation
- Screening/Surveillance Colonoscopy
- Intracranial Hemorrhage or Cerebral Infarction
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction (STEMI) with PCI

Attribution

- Triggering event by code or 30% of inpatient E/M in MS-DRG
- Defined global

TABLE 37: Percentage of TINs and TIN/NPIs with 0.4 or Higher Reliability from June 1, 2016 to May 31, 2017 at Proposed Case Minimums

Measure name	Percentage TINs with 0.4 or higher reliability	Mean Reliability for TINs	Percentage TIN/NPIs with 0.4 or higher reliability	Mean Reliability for TIN/NPIs
Elective Outpatient Percutaneous Coronary Intervention (PCI)	100.0%	0.73	84.1%	0.53
Knee Arthroplasty	100.0%	0.87	100.0%	0.81
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	100.0%	0.74	100.0%	0.64
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	100.0%	0.95	100.0%	0.94
Screening/Surveillance Colonoscopy	100.0%	0.96	100.0%	0.93
Intracranial Hemorrhage or Cerebral Infarction	100.0%	0.70	74.9%	0.48
Simple Pneumonia with Hospitalization	100.0%	0.64	31.8%	0.40
ST-Elevation Myocardial Infarction (STEMI) with PCI	100.0%	0.59	100.0%	0.59



MSPB_1 Medicare Spending Per Beneficiary (MSPB)

- The MSPB measure evaluates solo practitioners and groups on their spending efficiency and is specialty-adjusted to account for their specialty mix. Solo practitioners and groups are identified by their NPI and TIN combination.
- Specifically, the MSPB measure assesses the average spend for Medicare services performed by providers/groups per episode of care.
- Each episode comprises the period immediately prior to, during, and following a patient's hospital stay.



Facts and differences

- CMS will establish a single, national benchmark for each cost measure
 - These benchmarks are based on the performance period, not a historical baseline period
 - 2018 Cost performance category score will be based on CY 2018 claims data
- In the VMB Program, cost measures were attributed to a TIN
 - For MIPS, CMS will attribute cost measures at the TIN/NPI level
 - Although cost measures will be attributed to individual clinicians, cost measure performance *can be assessed* by CMS at either the individual clinician level or group level
 - For groups participating in group reporting in other MIPS performance categories, their cost performance category scores will be determined by aggregating the scores of the individual clinicians within the TIN



TPCC_1 Total Per Capita Costs (TPCC)

- The TPCC measure is a payment-standardized, annualized, risk-adjusted, and specialty-adjusted measure that
- Evaluates the overall efficiency of care provided to beneficiaries attributed to solo practitioners and groups, as identified by their Medicare TIN



MSPB Episodes



- Minimum case volume for the MSPB measure is 35
- Risk adjusted to account for beneficiary age and illness severity
- Medicare A & B claims during the episode window

ATTRIBUTION

Clinician (TIN/NPI) responsible for the plurality of Part B clinician/supplier services

- Services provided on the admission date and in hospital inpatient, outpatient or emergency room places of service (POS)
- Services provided during the index hospital stay, regardless of POS
- Services provided on the discharge date with inpatient hospital POS only

If tie (1) attributed to most amount of line items or (2) if equal, randomly selected



TPCC Calculation

ATTRIBUTION

1. Step 1: Beneficiary received E/M from a PCP or NPP
2. Step 2: If no E/M from PCP/NPP then assigned to specialist

- Minimum case volume for the TPCC is 20
- Risk adjusted to account for beneficiary age and illness severity
 - CMS-Hierarchical Condition Category (CMS-HCC) risk score and End Stage Renal Disease (ESRD) status
- CMS applies specialty adjustment to the TPCC measure
 - National average per capita cost for each specialty
- Medicare B claims during the calendar year



TPCC Denominator

Table 2. Healthcare Common Procedure Coding System (HCPCS) Primary Care Service Codes

HCPCS Codes	Brief description
99201–99205	New patient, office, or other outpatient visit
99211–99215	Established patient, office, or other outpatient visit
99304–99306	New patient, nursing facility care
99307–99310	Established patient, nursing facility care
99315–99316	Established patient, discharge day management service
99318	New or established patient, other nursing facility service
99324–99328	New patient, domiciliary or rest home visit
99334–99337	Established patient, domiciliary or rest home visit
99339–99340	Established patient, physician supervision of patient (patient not present) in home, domiciliary, or rest home
99341–99345	New patient, home visit
99347–99350	Established patient, home visit
99487, 99489	Complex chronic care management
99495-99496	Transitional care management
99490	Chronic care management
G0402	Initial Medicare visit
G0438	Annual wellness visit, initial
G0439	Annual wellness visit, subsequent
G0463	Hospital outpatient clinic visit (Electing Teaching Amendment hospitals only)



TPCC patient attribution for MIPS cost

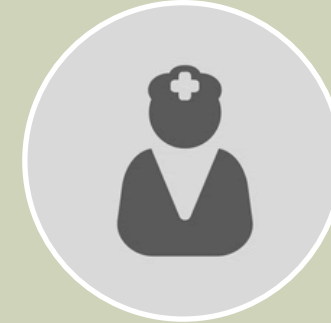


Primary care services

- E/M by clinician



If no clinician in PCP specialty, attributed to highest E/M clinician in certain specialties



PCP specialties:

- General practice, family practice, internal medicine, gerontology
- NPPs are included
 - Clinical Nurse Specialists
 - Nurse Practitioners
 - Physician Assistants



TPCC specialists Included for attribution

Medical Specialists

- Addiction Medicine (79)
- Allergy/Immunology (03)
- Cardiac Electrophysiology (21)
- Cardiology (06)
- Critical Care (Intensivists) (81)
- Dentist (C5)
- Dermatology (07)
- Endocrinology (46)
- Gastroenterology (10)
- Geriatric Psychiatry (27)
- Hematology (82)
- Hematology/Oncology (83)
- Hospice and Palliative Care (17)
- Infectious Disease (44)
- Interventional Cardiology (C3)
- Interventional Pain Management (09)
- Medical Oncology (90)
- Nephrology (39)
- Neurology (13)
- Neuropsychiatry (86)
- Osteopathic Manipulative Medicine (12)
- Physical Medicine and Rehabilitation (25)
- Preventive Medicine (84)
- Psychiatry (26)
- Pulmonary Disease (29)
- Rheumatology (66)
- Sleep Medicine (C0)



TPCC specialists Included for attribution

Other Physicians

- Anesthesiology (05)
- Chiropractic (35)
- Diagnostic Radiology (30)
- Emergency Medicine (93)
- Interventional Radiology (94)
- Nuclear Medicine (36)
- Optometry (41)
- Pain Management (72)
- Pathology (22)
- Pediatric Medicine (37)
- Podiatry (48)
- Radiation Oncology (92)
- Single or Multispecialty Clinic or Group Practice (70)
- Sports Medicine (23)
- Unknown Physician Specialty (99)

Surgeons

- Cardiac Surgery (78)
- Colorectal Surgery (28)
- General Surgery (02)
- Gynecological/Oncology (98)
- Hand Surgery (40)
- Maxillofacial Surgery (85)
- Neurosurgery (14)
- Obstetrics/Gynecology (16)
- Ophthalmology (18)
- Oral Surgery (Dentists Only) (19)
- Orthopedic Surgery (20)
- Otolaryngology (04)
- Peripheral Vascular Disease (76)
- Plastic and Reconstructive Surgery (24)
- Surgical Oncology (91)
- Thoracic Surgery (33)
- Urology (34)
- Vascular Surgery (77)



TPCC specialists **EXCLUDED** for attribution

Practitioners

- Anesthesiologist Assistant (32)
- Audiologist (Billing Independently) (64)
- Certified Nurse Midwife (42)
- **Certified Registered Nurse Anesthetist (43)**
- Clinical Psychologist (68)
- Clinical Psychologist (Billing Independently) (62)
- Licensed Clinical Social Worker (80)
- Registered Dietician/Nutrition Professional (71)

Therapists

- Occupational Therapist in Private Practice (67)
- Physical Therapist in Private Practice (65)
- Speech Language Pathologists (15)



Frequently Asked Questions

What happens if a provider does not have any patients attributed in Cost and thus have no score? Is it reweighted?

Yes, the score is reweighted to Quality.

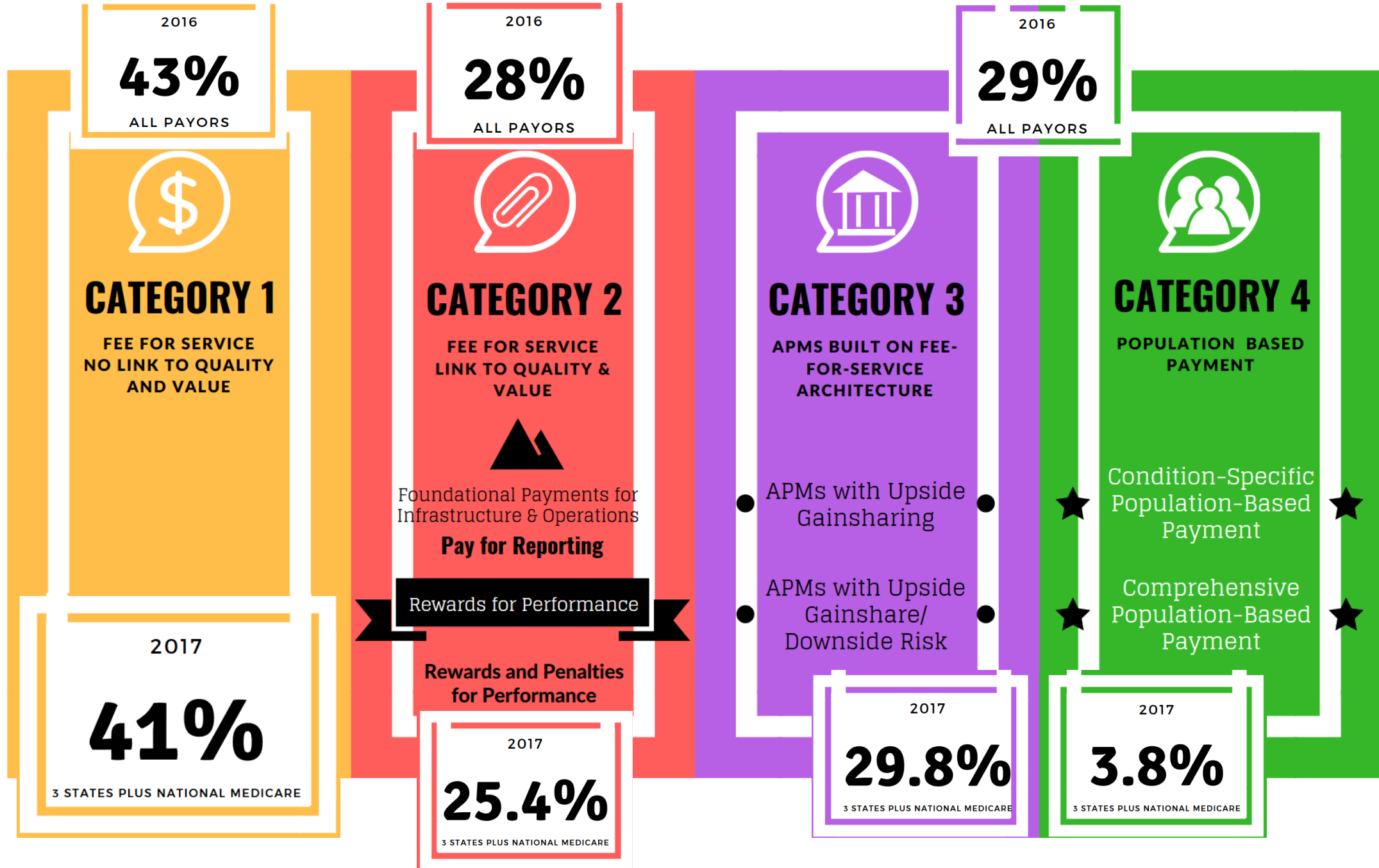
How will CMS evaluate radiologists for cost? Radiologists do not control referrals for exams.

Because of the attribution method for the two cost measures, it is very unlikely that radiologists or radiology groups will have patients attributed to them for the Cost category. In this case, the category will be reweighted to 0% and the 10% will be added to the weight for the Quality category. Radiologists who are part of a multispecialty group that included primary care clinicians may receive the Cost score based on the group's performance.



Enough about MIPS

APMs, Cost Transparency, and hot topics



Source: Health Care Payment and Learning Action Network. Alternative Payment Model Framework, Final White Paper & 2018 APM Measurement Report.

ADVANCED APMS

2018 Statistics

86



Comprehensive Care for Joint Replacement Payment Model

This voluntary orthopedic bundle program for hospitals requires CEHRT adoption.

37

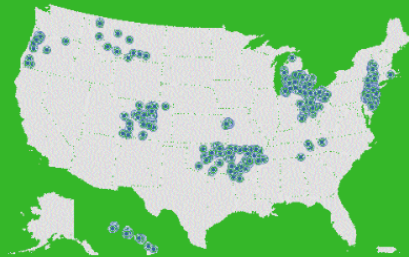
Comprehensive ESRD Care Model

Seamless Care Organizations identify, test and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD) in this two-sided risk model.

2,932

Comprehensive Primary Care Plus

CPC+ is available in 18 regions and supported by 51 aligned private payors.



Source: CMS & CMMI, Sept. 2018.

Announced participants: **26**
Medicare Diabetes Prevention Program

101

Medicare Shared Savings Program - Tracks 1+, 2 & 3

The revised model for accountable care organizations (ACOs) with varying levels of risk, chronic care services and global periods.



51

Next Generation ACO Model

Building on the Pioneer ACO model, this demonstration sets predictable financial targets with up and downside risk.

179

Oncology Care Model

Model provides highly coordinated oncology care in collaboration with 13 private payors.



Oct. 1

Bundled Payments for Care Improvement - Advanced Model

This latest iteration of bundled payments will test payment models for 32 Clinical Episodes and aim to align incentives. The first round of applications is due Oct. 1, 2018 with performance through Dec. 31, 2023.



Performance transparency

Medicare.gov Provider Directory = Physician Compare

- PQRS, MU and other data already available on system
- “Late 2018” = posting of 2017 QPP performance scores
- Annual update of directory
 - Will show all data submitted

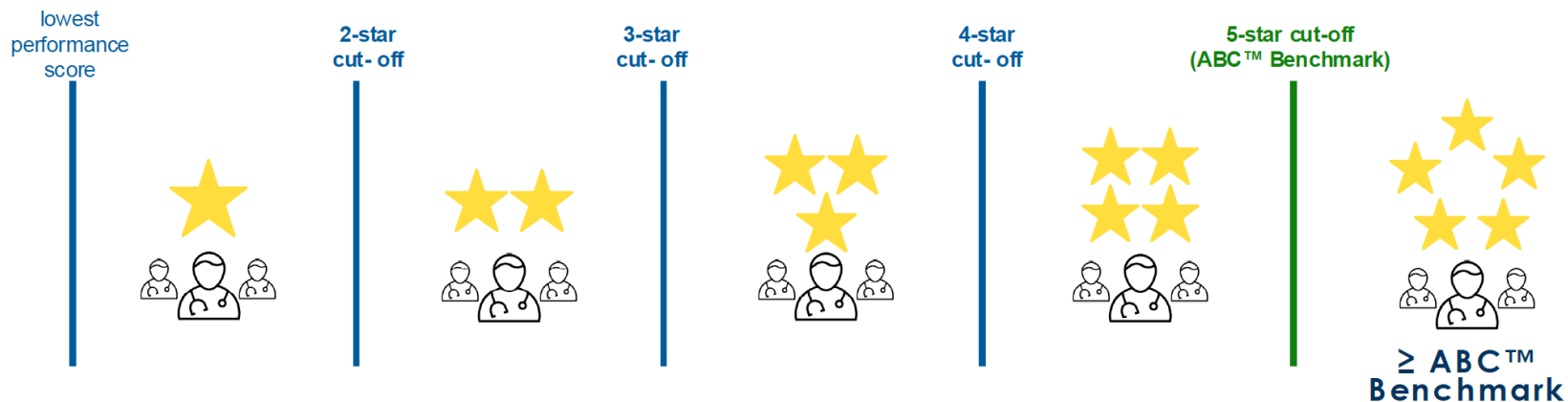


Improving health care quality

Physician Compare tells you about what clinicians are doing to improve your care.

[Learn more](#)

- ✓ [Used electronic health records.](#)
- ✓ Successfully reported Medicare quality program performance information.





Performance transparency – cont.

- Same format as have had in past – *nothing new*
 - Star rating for each measure reported

Proposed format

Screening for tobacco use and providing help quitting when needed.



Hide

More stars are better because it means clinicians in this group provided counseling to more patients who used tobacco and encouraged them to quit.

Quitting tobacco lowers a patient's chance of getting heart and lung diseases.

To give this group a star rating, Medicare looked at the percentage of this group's patients who were asked if they used tobacco at least once in the last two years. If patients were using tobacco, the clinician spoke with them about ways to help them quit using tobacco.

Current format - physicians

Screening for tobacco use and providing help quitting when needed.



Show

Current format - ACOs

Screening for an unhealthy body weight and developing a follow-up plan.

82.14%

Show

Getting a flu shot during flu season.

56.05%

Show



CAHPS performance transparency

Current format

Getting timely care, appointments, and information.	Not available ⁴	Show +
How well clinicians communicate.	78%	Show +
Health promotion and education.	54%	Show +
Patients' rating of clinicians.	80%	Show +
Courteous and helpful office staff.	79%	Show +
Clinicians working together for your care.	69%	Show +
Between visit communication.	47%	Show +
Attention to patient medicine cost.	19%	Show +

Source: Centers for Medicare & Medicaid Services



Hospital Compare – Medicare.gov

Review hospitals on Quality & Cost

<https://www.medicare.gov/hospitalcompare/search.html>

Compare Hospitals

[Back to Results](#)

General information

Survey of patients' experiences

Timely & effective care

Complications & deaths

Unplanned hospital visits

Use of medical imaging

Payment & value of care

THOMAS JEFFERSON UNIVERSITY HOSPITAL
111 SOUTH 11TH STREET
PHILADELPHIA, PA 19107
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Overall rating ⓘ



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[View rating details](#)

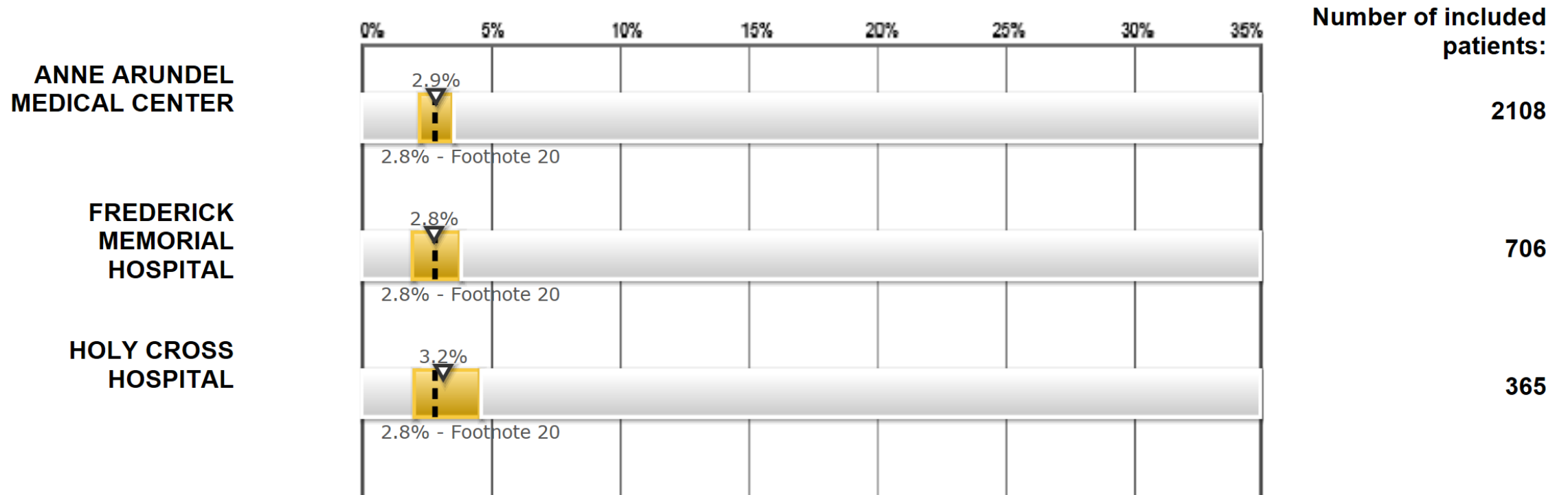
Distance ⓘ: 0.8 miles

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Hospital Compare – Medicare.gov

- Other Data...Surgical Complication





Surgeon Complication Rate

ProPublica

<https://projects.propublica.org/vital-signs/>

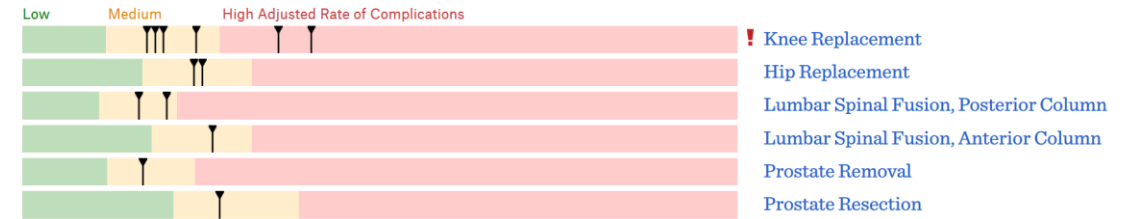
DOCTORS' COMMUNITY HOSPITAL

8118 GOOD LUCK ROAD, LANHAM, MARYLAND, 20706, PHONE: 301-552-8085

How Surgeons at This Hospital Perform, by Procedure

KEY: | An individual surgeon who performs this procedure at this hospital.

! At least one surgeon performing this procedure has a high adjusted rate of complications.



PERFORMED PROCEDURE

COMPLICATIONS

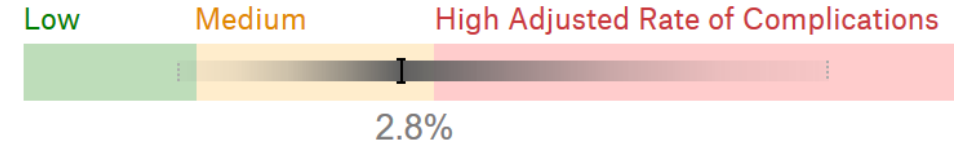
RAW COMPLICATION RATE

80 times

1-10

Redacted

ADJUSTED COMPLICATION RATE



SURGEONS PERFORMING THIS PROCEDURE WITHIN 25 MILES →

[SEE AREA HOSPITALS »](#)

PERFORMED PROCEDURE

COMPLICATIONS

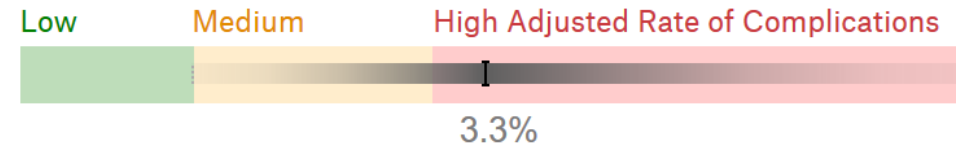
RAW COMPLICATION RATE

32 times

1-10

Redacted

ADJUSTED COMPLICATION RATE



SURGEONS PERFORMING THIS PROCEDURE WITHIN 25 MILES →

[SEE AREA HOSPITALS »](#)

This Surgeon

This Surgeon



Maryland Health Care Commission - WearTheCost.org

Hip Replacement

COST FOR
TYPICAL CARE

COST FOR POTENTIALLY AVOIDABLE
COMPLICATIONS

AVERAGE TOTAL COST

Show

Costs We Know



Let's talk about
HIP REPLACEMENT
COSTS



Let's talk about
KNEE REPLACEMENT
COSTS



Let's talk about
HYSTERECTOMY
COSTS



Let's talk about
VAGINAL DELIVERY
COSTS

8. Holy Cross Hospital



\$30,207

Show
Cost
Breakdown



USING THE DATA – Non-procedural specialist

	2018	2017	2016
Board certified	Nearly required	Yes	Yes
Hospital privileges	Specialty specific	N/A	N/A
EMR adoption	Nearly required	Stage 2	Stage 2
ePrescribe	Controlled substances coming	>90% w/controlled substances	>90% w/o controlled substances
Query PDMP	Volume %	Yes	Yes
Tobacco Cessation	100%	92%	80%
BP Screening	10%	5%	-
\$ from pharma (% to natl av)	Public data!!	304%	-30%
Payments per patient		96 th percentile	98 th percentile
Patient rating of clinician		80%	82%
Patient rating of communication		78%	65%




USING THE DATA – Non-procedural specialist

	2017	2016
Board certified	Yes	Yes
Hospital privileges	N/A	N/A
EMR adoption	Stage 2	Stage 1
ePrescribe	>90% w/controlled substances	>90% w/o controlled substances
Query PDMP	Yes	Yes
Tobacco Cessation	ACO – 95%	ACO – 92%
Depression Screening	ACO – 31%	ACO – 15%
\$ from pharma (% to natl av)	-83%	-90%
Payments per patient	69 th percentile	72 nd percentile
Patient rating of clinician	92%	91%
Patient rating of communication	85%	78%



USING THE DATA – Proceduralist 1

	2017	2016
Board certified	Yes	Yes
Hospital privileges	Holy Cross Hospital 	
Personal complication rate (% median)	22%	78%
Rehospitalization rate	0%	6%
EMR adoption	None	None
ePrescribe	None	None
Query PDMP	Yes	No
Tobacco Cessation	83.34%	54.32%
Depression Screening	38.87%	14.98%
\$ from pharma (% to natl av)	1994%	1160%
Payments per patient	63 rd percentile	77 th percentile



USING THE DATA – Proceduralist 2

	2017	2016
Board certified	Yes	Yes
Hospital privileges	Doctor's Community Hospital ★★☆☆●●	
Personal complication rate (% median)	-2%	-10%
Rehospitalization rate	22%	7%
EMR adoption	-	-
ePrescribe	>90% w/controlled substances	19/24
Query PDMP	Yes	Yes
Tobacco Cessation	ACO – 95%	ACO – 72%
Depression Screening	ACO – 31%	ACO – 5%
\$ from pharma (% to natl av)	-20%	-93%
Payments per patient	28 th percentile	34 th percentile



Transparency & Performance Monitoring

Holding
 Clinicians
 Accountable

SUFFIX	EMPLOYMENT	AV QUALITY PERF	128 BMI	130 DOC RX	131 PAIN	226 TOBACCO
MD	Full-time	0%	0%	0%	0%	0%
FNP	Inactive	33%	0%	0%	0%	0%
PA	NPP	7%	0%	0%	0%	0%
CRNP	Inactive	18%	36%	30%	30%	13%
CRNP	Inactive	33%	100%			
MD	Full-time	29%	49%	50%	50%	26%
PA-C	NPP	27%	44%	48%	48%	21%
MD	Full-time	29%	56%	50%	51%	16%
DPM	Full-time	30%	60%	50%	52%	16%
MD	Inactive	28%	44%	56%	56%	15%
MD	Full-time	26%	60%	40%	42%	17%
MD	Full-time	31%	53%	55%	57%	24%
MD	Full-time	58%	63%	58%	59%	26%
MD	Full-time	48%	71%	71%	71%	71%
MD	Full-time	37%	26%	23%	24%	5%
MD	Full-time	36%	24%	24%	24%	8%
MD	Full-time	29%	23%	19%	20%	2%
MD	Full-time	18%	0%	38%	38%	34%
MD	Full-time	44%	100%	84%	38%	42%

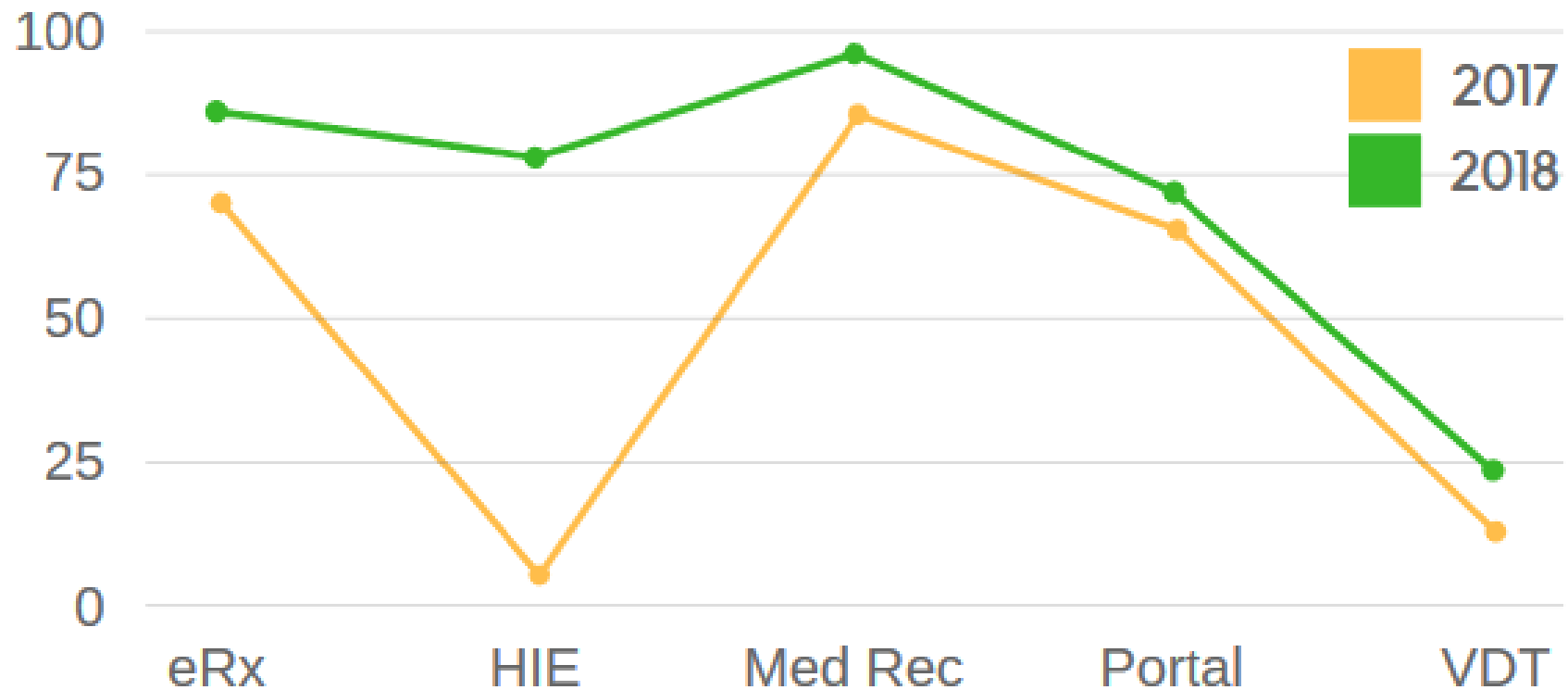
- Compare within group
- Compare within specialty
- Compare within region
- Compare within groups reporting same measure



Transparency & Performance Monitoring

- Improvement in EMR utilization

Promoting Interoperability (formerly Meaningful Use)





Why did you go into healthcare?



AMERICAN OSTEOPATHIC ASSOCIATION

Any AOA member reporting MIPS data through SCG Health in 2018 will receive a 10% discount off the full retail cost of \$275/clinician. SCG Health also offers data entry support starting at \$500/clinician (discount not applicable). Enrollment closes February 15, 2019.

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[+ Our Favorite Improvement Activities](#)



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support@SCGhealth.com



FREE
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Only 20 seats each
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Register at
SCGhealth.com

Saturday, December 1, 2018
Wednesday, December 5, 2018

MIPS INTENSIVE

SCG Health HQ, Winchester Virginia
Register at SCGhealth.com

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The Physician Consortium for
Performance Improvement®
wants you!

ONE-TIME SCREENING FOR HEPATITIS C VIRUS FOR PATIENTS AT RISK

Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945-1965 who received one-time screening for hepatitis C virus (HCV) infection

ANNUAL HEPATITIS C VIRUS SCREENING FOR PATIENTS WHO ARE ACTIVE DRUG USERS

Percentage of patients aged 18 years and older with either (1) a positive HCV antibody test result and a positive HCV RNA test result or (2) a positive HCV antibody test result and an absent HCV RNA test result who are prescribed treatment or are referred to evaluation or treatment services

APPROPRIATE SCREENING FOLLOW-UP FOR PATIENTS IDENTIFIED WITH HEPATITIS C INFECTION

Percentage of patients, regardless of age, who are active injection drug users who received screening for HCV infection within the 12 month reporting period

TO SIGN-UP

Call SCG Health at
888-886-8054 or email
support@SCGhealth.net



Calling all Hep C Offices!

PCPI needs your help
developing 3 EMR
measures

Volunteer on our website!



**PERSONAL RELATIONSHIPS ARE
ALWAYS THE KEY TO GOOD BUSINESS.
YOU CAN BUY NETWORKING;
YOU CAN'T BUY FRIENDSHIPS.
-LINDSAY FOX**



THE ART AND
SCIENCE
OF ASKING
QUESTIONS
IS THE
SOURCE OF ALL
KNOWLEDGE.
-THOMAS BERGER