Marching Towards MIPS

The 2016 Regulatory Landscape for LTPAC Medical Providers

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Disclosure

I am an employee of Geriatric Practice Management. My company developed and sells gEHRiMed, a commercially available portable EHR designed for LTC Physicians and practices.

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Learning Objectives

Upon completion of this class, participants will be able to:

1. Apply basic knowledge of the regulatory landscape change from volume to value, as reflected in the 4 components of MIPS, in a practical way.
2. Name one regulatory reason and one patient care reason why specific and complete ICD-10 coding (and corresponding documentation) are best practices.
3. Discuss 2 ways that the adoption of CEHRT, structured data standards, and the movement toward interoperability may improve patient transitions, and therefore the cost and quality of care.

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Landscape Survey

Current State

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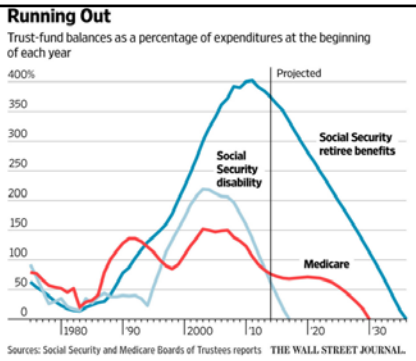
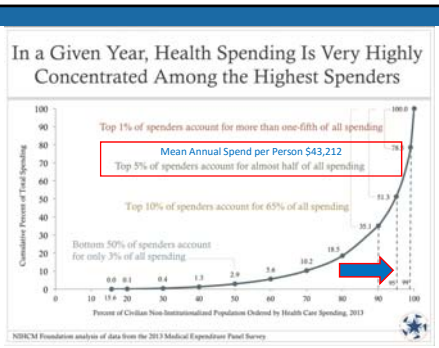
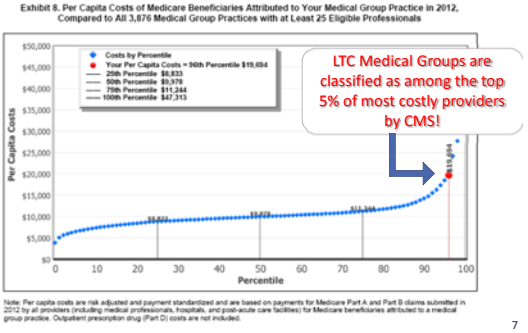
Escalating healthcare costs in light of depleting Medicare funds



http://www.wsj.com/articles/social-security-trust-fund-faces-depletion-in-2034-1437586367



http://www.nihcm.org/component/content/article/11-charts/1507-health-care-s-big-spenders-the-characteristics-behind-the-curve (2013 data)



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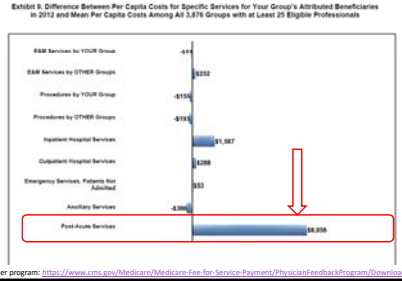
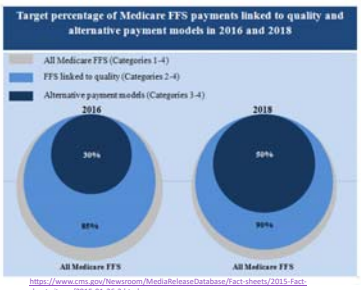
The CMS Push to Payment Reform is now focused on LTPAC



Cost measures in the Value Modifier program: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014-QRUR-FAQs.pdf

Volume to Value: Quality rather than Quantity

HHS seeks to have 85% of Medicare fee-for-service payments in value-based purchasing categories by 2016 and 90% by 2018.



https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

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Alternative Payment Models and Initiatives Sprouting up Everywhere

CMS is trying to reduce cost, increase quality, and improve patient outcomes in the pursuit of the Triple Aim

- Alternative Payment Models (APMs)
  - MSSP
  - Patient Centered Medical Home
  - BCPI
- CMS Innovation Center
  - Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents
- CJR – started 4/1/16
- Comprehensive Primary Care Plus – starts January 2017
- Home-based Primary Care
- Million Hearts® CVD model

Current State vs. Future State

- **Current State**
  - Paid per RVU for each CPT
  - Care coordination by phone, fax, and reviewing records (paper or electronic)
  - Facilities house the patient care plan and often drive who needs to be seen
  - Population health and tracking patient outcomes through transitions is a relatively new model of care in practice
- **Future State**
  - Payment will be adjusted based on quality and cost, not number of visits
  - Managing populations across places of service longitudinally and by episode will be the basis of alternative payment models
  - Medical providers will be even more involved in tracking outcomes, in chronic condition care plans, and managing of hospitalizations and potential re-hospitalizations
  - More and more communication will be electronic
  - True interoperability with structured data sharing will start to become reality and is the objective of Meaningful Use Stage 3 (starts in 2017)

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Current State: Medical Provider Quality = PQRS

- Individual Measures, Measures Groups, eCQMs from the Meaningful Use program
- Report as individuals or groups or as part of an ACO
- Report successfully to avert PQRS and VM penalties in 2018
  - Physician Practices of 1-9 EPs
    2% PQRS penalty + 2% VM penalty = 4% of MPFS downward adjustment
  - Physician Practices of 10+ EPs
    2% PQRS penalty + 4% VM penalty = 6% of MPFS downward adjustment
  - Non-physician Practices – all sizes
    2% PQRS penalty + 2% VM penalty = 4% of MPFS downward adjustment
- QRURs help you evaluate your performance (one year later)

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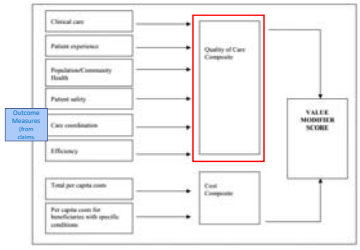
Scored quality measures populate the Value Modifier Quality of Care Composite

- The domains that contribute to the Quality of Care Composite Score are populated by successfully reported PQRS measures and outcomes measures from claims. All 6 domains are equally weighted.
- The 3 outcomes measures from claims are part of the Care Coordination domain.



Domains for Popular LTPAC Measures Groups

Domain	CAD	HF	Dementia	Parkinson's
Effective Clinical Care				
Patient Experience				
Community/ Population Health				
Care Coordination				
Patient Safety				
Efficiency				

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Value Modifier Program (Quality + Cost)

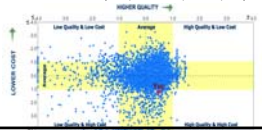
PQRS Data + Outcome Measures (from claims) + Cost Measures (from claims)

- All Cause Readmission
- Composite of Acute Prevention Quality Indicators (bacterial pneumonia, UTI, dehydration)
- Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes, CAD)

Impacted by the risk adjustment factor assigned to the patient from your **prior year** diagnoses

Quality Composite Score

Cost Composite Score



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Value Based Purchasing quality tiering in 2018

(practices with 10+ and at least one physician shown below)

-4% Low quality High cost

-3%

-2% Average quality High cost

-1%

0% High quality High cost

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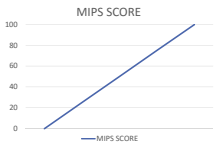
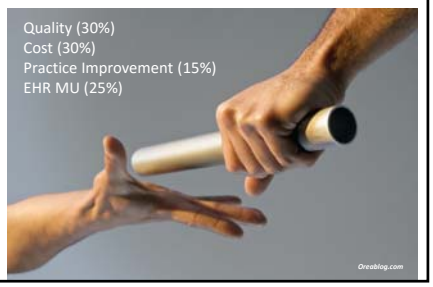
The Merit-Based Incentive Payment System (MIPS)

MIPS adds 2 additional runners to the provider performance relay team





Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Signed into Law **4/16/2015**
- Repealed 1997 Sustainable Growth Rate Physician Fee Schedule (PFS) Update and added PFS 0.5% update CY2016 -CY2019
- Sunsets PQRS, the Value Modifier and Medicare Meaningful Use as you know them on 12/31/2018.
- Made sweeping changes to the Medicare PFS Payment 2019 forward

Merit-Based Incentive Payment System (MIPS)

Incentives for participation in Alternate Payment Model (APM)

QP

QP

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What is an eligible APM?

Eligible APMs are the **most advanced** APMs that meet the following criteria according to the MACRA law:

- ✓ **Base payment on quality** measures comparable to those in MIPS
- ✓ Require use of certified **EHR** technology
- ✓ Either (1) bear more than nominal **financial risk** for monetary losses **OR** (2) be a **medical home model expanded** under CMMI authority

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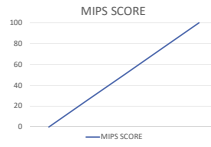
MIPS Composite Performance Score

- Performance assessment in four categories using weights established in the statute.
  - EHR weighting can be decreased and shifted to other categories if the Secretary estimates the proportion of physicians who are meaningful EHR users is 75% or greater (statutory floor for EHR weight is 15%)
- **Weights may be adjusted if there are not sufficient measures and activities applicable for each type of EP, including assigning a scoring weight of 0 for a performance category.**
- **Performance thresholds** will be established based on the mean or median of the composite performance scores for all MIPS EPs during a period prior to the performance period.
- CMS must make feedback reports available timely ("such as quarterly") starting July 1, 2017.



MIPS Payment Adjustments

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.

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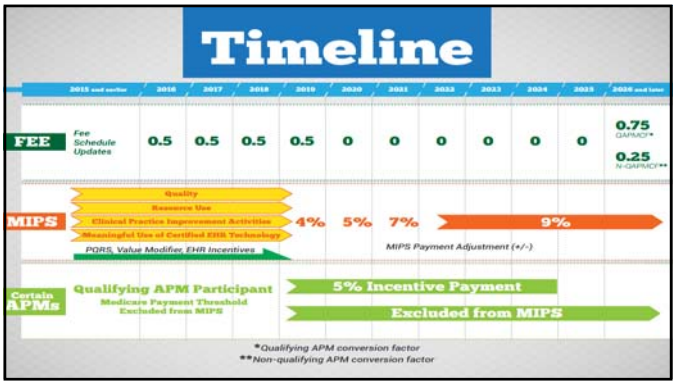

MIPS and APMs are endurance events, not sprints!

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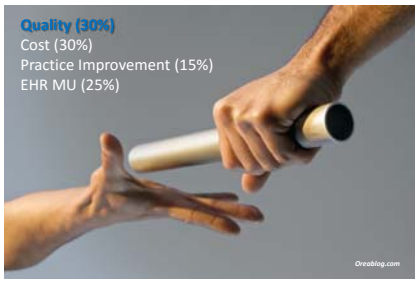
Quality

Formerly the PQRS Program



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Meaningful measures in MIPS?

The list of measures for MIPS will be published no later than November 1st, 2016.

- The quality measures may include updates and modifications to previous quality measures and the removal of topped out measures (as is the current practice).
- EPs will select the measures they wish to report. Measures that don't apply to a provider will not impact his/her quality score.
- MACRA emphasizes outcomes measures.
- Priorities for measure development include:
  - Clinical outcome, patient reported outcome, and functional status measures
  - Patient and Caregiver Experience
  - Care coordination (across the continuum, emphasis on chronic care)
  - Appropriate use of services including measures of overuse
- Population-based measures are allowed for MIPS.
- $15 million per year has been provided for 5 years for measure development

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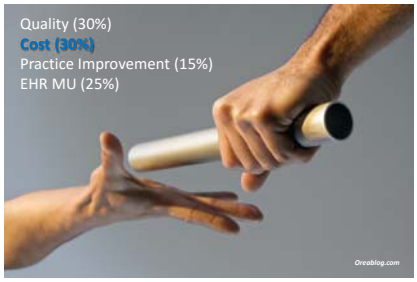
Resource Use

Formerly the Value Modifier Program



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ICD-10-CM improvements tie diagnoses to the cost of quality care

CMS ties diagnosis coding to cost and quality evaluation – sounds a lot like the VM program doesn't it? The CMS June 2015 MLN document ICN 901044 (https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10Overview.pdf) states ICD-10-CM improvements include:

1. Much greater specificity and clinical information, which results in:
   - Improved ability to measure health care services;
   - Increased sensitivity when **refining** grouping and **reimbursement methodologies**;
   - Enhanced ability to conduct public health surveillance; and
   - **Decreased need to include supporting documentation** with claims;
2. Updated medical terminology and classification of diseases;
3. Codes that allow comparison of mortality and morbidity data; and
4. Better data for:
   - **Measuring care** furnished to patients;
   - **Designing payment systems**;
   - Processing claims;
   - Making clinical decisions;
   - Tracking public health;
   - **Identifying fraud and abuse**; and
   - Conducting research.

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The key to finding the right ICD-10 code is a good search strategy

While you can enter memorized ICD-9 codes in your search, learning the recommended search strategy for your EHR may yield higher quality results.

(and you won't need to unlearn habits when specific diagnosis coding is more closely tied to outcomes-based reimbursement).

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Take advantage of ICD-10 Code specificity

- Take advantage of specific coding when you have sufficient detail or knowledge to assign a more specific code.
- Codes can be refined to indicate laterality, cause, type and chronicity.
  - Is the anemia chronic or acute due to a GI bleed?
  - Is the asthma mild intermittent, mild persistent, moderate persistent or severe persistent?
  - Is the pressure ulcer at the right or the left greater trochanter?
- ICD-10 codes can now account for disease relationships indicating higher patient acuity. How many elderly diabetics do you know who actually have no complications?
- Transition flexibility with the family of code (ICD-10 three-character category), slated to end 9/30/16.

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Specific diagnoses paint the patient picture

- Accurate and specific coding not only helps account for costs but it also:
  - helps with transitions of care in case of ER visit or hospital readmission (problem list from a C-CDA is below)
  - increases the chance that significant problems will be monitored as often as medically necessary and emergency care/rehospitalization will be less likely
  - encourages providers to assess and re-evaluate chronic diagnoses each year
  - assists in continuity of care providing caregivers a complete picture of the patient's health at the facility for on call providers and team care between physicians and NP/PAs

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Specific coding may help account for the costs related to frailty and multiple comorbid chronic conditions

- Risk Adjustment Model: HCCs are one indicator of patient acuity
  - The HCC model uses patient demographics and the patient's ICD-9 problems (associated with your ICD-10 diagnoses) captured during all clinician encounters in all settings each calendar year.
  - Condition categories that don't predict costs well are not included in the model – so not every diagnosis with an associated ICD-9 code has an HCC value.
  - **Each patient's health status must be re-determined each year.** All qualifying diagnoses submitted to CMS in a given year for a particular patient are added to achieve a total health status "score" for a patient. Each year the ledger is erased and HCCs reset to 0.
  - The VM program compares your risk adjusted costs based on these health status "scores" to predicted costs and then benchmarks you against your peers. Risk adjustment for the current year is based on the prior year's diagnoses.

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Specific coding and documentation of chronic conditions can help support a patient's high risk of morbidity and mortality

Examples:

- Amputation (HCC = 0.265)
- Artificial Openings for Feeding or Elimination (HCC = 0.651)
- Protein-Calorie Malnutrition (HCC = 0.713)
- Ventilator Dependence (HCC = 1.520)
- Chronic Paraplegia (HCC = 1.052)
- Long standing conditions that impact quality of life, increase the need for assistance, or impact balance (old MI, old CVA, chronic lung conditions, etc.)
  - CVA, old, hemiparesis (HCC = 0.581)
  - Chronic bronchitis (HCC = 0.346)

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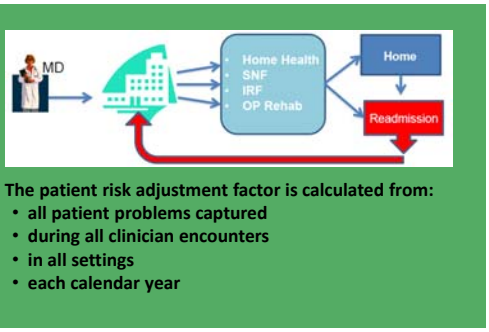

The patient risk adjustment factor is calculated from:

- **all patient problems captured**
- **during all clinician encounters**
- **in all settings**
- **each calendar year**

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All conditions coded appropriately		Some conditions coded poor specificity		No conditions coded	
76 year old female	.468	77 year old female	.468	78 year old female	.468
Medicaid eligible	.177	Medicaid eligible	.177	Medicaid eligible	.177
Diabetes w/ vascular complications (HCC 15)	.608	Diabetes w/o complications (HCC19)	.181	No diabetes coded	
Vascular disease w/complication (HCC 104)	.645	Vascular disease w/o complications (HCC105)	.324	No Vascular disease	
CHF (HCC80)	.395	CHF not coded		CHF not coded	
Disease Interaction (DM + CHF)	.204	No Disease Interaction		No Disease Interaction	
Total RAF	2.497	Total RAF	1.15	Total RAF	.645
PMPM Payment	$2,263	PMPM Payment	$1,042	PMPM Payment	$585
Annual Payment	$27,159	Annual Payment	$12,508	Annual Payment	$7015

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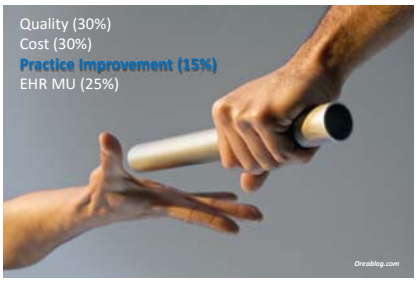
Clinical Practice Improvement



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CMS examples – Stay tuned to the MIPS Proposed Rule

MIPS- Clinical Practice Improvement Activities:

The Secretary is required to specify clinical practice improvement activities. Subcategories of activities are also specified in the statute, some of which are:

Expanded Practice Access	Population Management	Care Coordination	Beneficiary Engagement
• Same day appointments for urgent needs • After hours clinician advice	• Monitoring health conditions & providing timely intervention • Participation in a qualified clinical data registry	• Timely communication of test results • Timely exchange of clinical information with patients AND providers • Use of remote monitoring • Use of telehealth	• Establishing care plans for complex patients • Beneficiary self-management assessment & training • Employing shared decision making

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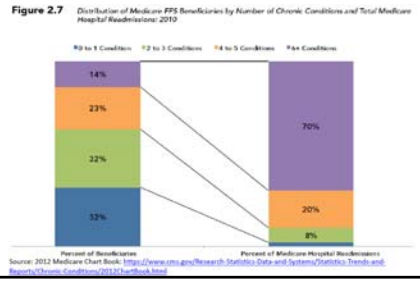
Medicare Readmissions by Number of Chronic Conditions



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CMS Special Study on Potentially Avoidable Transfers

Expert Panel Review of Potentially Avoidable Transfers

Contributing Factors	Resources Needed to Manage in the NH
Better ***quality of care*** would have prevented or decreased severity of acute change	***Physician or physician extender*** present in nursing home at least 3 days per week
One ***physician visit*** could have avoided the transfer	Exam by ***physician or physician extender*** within 24 hours
Better **advance care planning** would have prevented the transfer	***Nurse practitioner*** involvement
The same ***benefits*** could have been achieved at a lower level of care	***Registered nurse*** (as opposed to LPN or CNA) providing care
The resident's overall condition limited his ability to ***benefit*** from the transfer	Availability of ***lab tests*** within 3 hours
	Capability for ***intravenous fluid*** therapy

Ouslander et al: J Amer Ger Soc 58: 627-635, 2010

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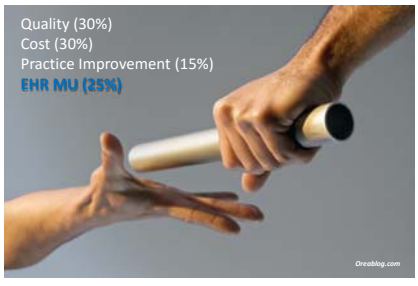
CEHRT

Meaningful Use



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Have you adopted CEHRT?

- EHR adoption in LTPAC Medical Groups is low compared to comparable ambulatory practices.
- Many AMDA Members are finally considering use of an EHR.
- CEHRT use is part of MIPS. If your fourth relay racer is benched, your other racers will have to do better to perform well in the race against your peers.

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Considering an EHR?

- The Medicaid Meaningful Use A/I/U Payment is based on acquiring ANY Ambulatory CEHRT – demonstrating MU is not required. The Entry Door (A/I/U $21,500) to the Medicaid EHR Payment Program **CLOSES FOREVER** at the end of 2016.
- Every Medicare Program assumes you are using an EHR.
- Most EHRs simplify the complexities of tracking and reporting Quality Measures.
- The physician penalties for not achieving MU continue if you do not qualify for a hardship exception (only get 5 years of hardship).

Performance Year	Payment Year	Medicare MU Penalty
2016	2018	3% penalty on Physicians only

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What should you look for in CEHRT?

- Certified to at least the ONC 2014 Edition of CEHRT. Ask your vendor if they will be ready for Stage 3 (2015) certification in 2017.
- Ask about ePrescribing, Direct Messaging, Patient Portals, and eCQM design
- Verify your EHR technology certification is up to date.

http://oncchpl.force.com/ehrcert/CHPLHome

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10 Objectives in Medicaid Modified Stage 2 Meaningful Use

- For 2016, a provider new to Meaningful Use can demonstrate for any continuous 90-day period between January 1, 2016 and December 31, 2016 .
- Any provider who has previously demonstrated Meaningful Use must report for a full calendar year in 2016. **January 1** was the beginning of your 2016 reporting year if you need to report for a full year.

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Interoperability

https://upload.wikimedia.org/wikipedia/commons/e/e7/Phodopus_sungorus_-_Hamsterkraftwerk.jpg

How to stop running the double-entry wheel…

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H.R.2 MACRA mandates EHRs must be interoperable by 2018

Consumer Access
No Blocking/Transparency
Standards

https://www.healthit.gov/commitment

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Items for interoperability

- Key items for most impact to improved care
  - Structured Medications
  - Structured Allergies
  - Diagnoses upon admission – medical providers will want to own the list, coding impacts their penalties, but it would help them not to have to do the initial admission diagnosis data entry (so long as they can edit)
- Items that will help providers with Meaningful Use and may enhance care communication/coordination
  - Code Status and Advanced Care Plan
  - Laboratory results
  - Falls screenings (IMPACT)
  - Immunizations
  - Depressions screens
  - Functional and cognitive assessments (IMPACT)

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"Medication Text blob" vs. Structured Medications

- Structured data can be passed electronically from one system to another correctly, a "text blob" cannot be consumed safely into a structured field.

metoprolol tartrate 50mg 1 by mouth 3 times daily
rivaroxaban 20 mg 1 tablet by mouth once a day
rosuvastatin calcium 10 mg 1 tablet by mouth once a day

Text blob

Generic Name	Strength	SIG	Date Started	Date Stopped	Status
rivaroxaban	20 MG	1 Tablet by mouth once a day	11/03/2015	Unknown	Active
Metoprolol Tartrate	50 MG	1 Tablet 3 times a day	11/03/2015	Unknown	Active
Rosuvastatin calcium	10 MG	1 Tablet by mouth once a day	11/03/2015	Unknown	Active

Structured medications

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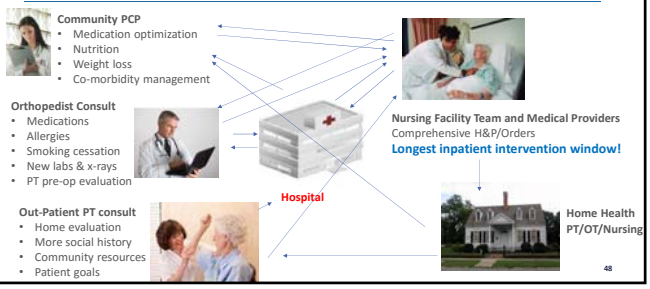
Data exchange for BPCI



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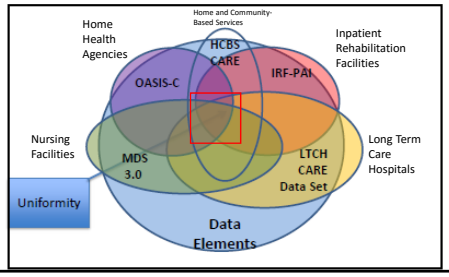
Standardized data elements needed to measure quality and resource use across the spectrum of care



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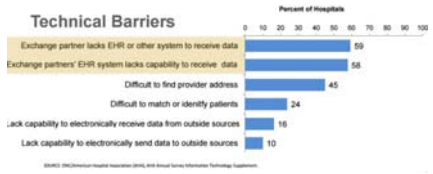
Data exchange challenges are significant

- Operational
- Technical



- Financial

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CMS and ONC paying more attention to PALTC

Announced at HIMSS16 in Las Vegas on March 2, 2016

> "That's why today, we are announcing an initiative to bring interoperable technology to a broader universe of health care providers, including long-term care, behavioral health providers, substance abuse treatment centers, and other providers that have been slower to adopt technology."

Andy Slavitt, Centers for Medicare & Medicaid Services (CMS) Acting Administrator

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FHIR: Emerging data exchange technology

- **F**ast **H**ealth **I**nteroperability **R**esources, is a proposed interoperability standard developed by the health care IT standards body known as HL7.
- Based on a modern web services approach
- FHIR uses modular components called "resources" which will allow fast exchange of very specific, well-defined pieces of information, rather than entire documents, upon provider query.
- FHIR will allow developers to create innovative apps that allow meaningful secure use of healthcare data as well as the exchange of data.
- Will be officially unveiled in 2017. Likely to take 2-3 years to adopt beyond early innovators/adopters.
- The Office of the National Coordinator JASON Task Force and others have made recommendations to the ONC to establish and maintain a set of public API standards. Assuming ONC follows the recommendations, EHR vendors would be required to use those Public APIs to obtain certification. If FHIR were to be designated as the Public API, the implications are far-reaching.

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Build your plane on the ground, not while it's in the air

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References

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