QPP YEAR TWO:
Clinical Practice Guidelines
Improving Quality of Care

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Speakers Disclaimer

- **D. Scott Jones, CHC** and **Richard E. Moses, DO, JD** do not have any financial conflicts to disclose.
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- The speakers are not promoting any service or product.

Overview

- **The Current State of Quality Payment Program (QPP) & Advanced Payment Models (APMs)**
- **Clinical Practice Guidelines (CPGs) & Quality**
- **Improving Quality of Care: What's Next?**
- **Summary & Conclusions**

3

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Quality Payment Program (QPP) & Advanced Payment Models (APMs)

2017: The QPP

- Rulemaking enacted by CMS under MACRA
- Streamlines multiple legacy quality reporting programs into the **Merit-based Incentive Payment System (MIPS):**
  - Physician Quality Reporting Program (PQRS)
  - Value Based Modifier (VM)
  - Medicare Electronic Health Records (EHR) Incentive Program
- Provides incentive payments for participation in **Advanced Alternative Payment Models (APMs)**

5

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program MACRA-NPRM-Slides.pdf

QPP 2017 – 2018 – 2019…and

- **Not participating** in the QPP earns a **negative payment adjustment** to the Physician Fee Schedule (2017 reduction of 4% will be reflected in CY 2019 FS payments)
  - Are you reporting in an APM, such as an Accountable Care Organization (ACO), or independently through MIPS?
  - Does your EMR vendor adequately support MIPS reporting?
  - Annual Data Submission Deadline: March 31, 20__
  - What are the 2018 Requirements?

6

QPP Training, Assistance, and Important Information

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html
- **New in 2018: "Virtual Group" status** – groups of solo providers or 10 or fewer providers who come together "virtually" – regardless of specialty or location – to participate as a group in MIPS for a minimum of one year. Note: The "election process" period has passed for 2018. Elect October-December 2017 for 2018 Virtual Group Status. MIPS_VirtualGroups@cms.hhs.gov

7

CMS Review of QPP: How's it going?

- Early Implementation Review of QPP: OEI-12-16-00400, 12/16
- Follow-up Review: CMS's Management of the QPP: OEI-12-17-00350, 12/17
  - **Developing IT:** "CMS appears to be on track to deploy the systems needed for data submission by January 1, 2018"
  - **Preparing Physicians:** "CMS has conducted outreach, communicated…issued sub-regulatory guidance…and established a Service Center…"
  - **Lack of assistance:** "…specialized, technical assistance to address practice-specific needs….Clinician uncertainty…"
  - **NO Program Integrity**, limited oversight of data integrity and data submission

8

QPP Final Rule 2018

- **MIPS Categories and Scoring: Add Cost to the Mix**
  - **Quality** 50 Points
  - **Cost** 10 Points
  - **Improvement Activities** 15 Points
  - **Advancing Care Information** 25 Points
  - **Possible Final Score:** 100 Points

9

QPP Final Rule 2018

- **Timelines**: Longer reporting periods for Quality, Cost
- **Quality** 12 Months required
- **Cost** (no submission) 12 Months required
- **Improvement Activities** 90 days required
- **Advancing Care Information** 90 days required
- **MIPS Reporting Period:** January 1 – December 31, 2018
- **Data Submission Deadline**: March 31, 2019; may submit early
- **FS Payment Adjustment**: January 1, 2020 – applied prospectively to each claim filed

10

QPP Final Rule 2018: MIPS Payment Adjustment

- Thresholds = +5% to -5% FS Payment Adjustment in 2021
- Must exceed 15 Point Minimum Threshold. Here's how:
  - Report Improvement Activities
  - Meet Advancing Care Information by reporting 5 measures and submit one medium-weighted Improvement Activity
  - Submit 6 Quality Measures
  - Quality data is calculated by CMS based on actual beneficiary cost
- Exceptional performers: 70 points earns a bonus of 5%
- 15.01-69.99 points = 0 to 5% positive adjustment
- 15 points = 0 payment adjustment
- < 15 points = negative adjustment up to -5%

11

What's it all about?

- CMS pays health plan contractors based on quality scores, using coding condition data on each beneficiary
- CMS and commercial health plans require a variety of hospital-based quality initiatives, medical practice, and ACO initiatives to measure reimbursement against quality scores
- Healthcare reimbursement is moving at all levels to quality-based payment models, and shifting cost risk to providers
- Increasing healthcare costs and ever increasing numbers of Medicare beneficiaries are driving the risk-sharing, quality-measurement system for reimbursement

12

Clinical Practice Guidelines & Quality

Overview of QPP

- MACRA
  - Requires Medicare Part B payment adjustments to clinicians based on quality & value…not volume of services provided
  - Required to start January 1, 2019
  - Adjustments determined by clinician's performance as assessed through one of two tracks:
    - MIPS
    - Advanced APMs
  - CMS refers to these 2 tracks as the QPP

https://qpp.cms.gov

Overview of QPP Tracks

Merit-Based Incentive Payment System (MIPS) Track

- Components of MIPS final score:
  - Quality
  - Advancing Care Information
  - Improvement Activities
  - Cost (not included in 2017 MIPS score)
- Payment adjustment: MIPS must be budget neutral, so CMS may scale positive payment adjustments as needed to achieve neutrality. High performers will be eligible for additional payments for exceptional performance.

OR

Advanced Alternative Payment Models (Advanced APMs) Track

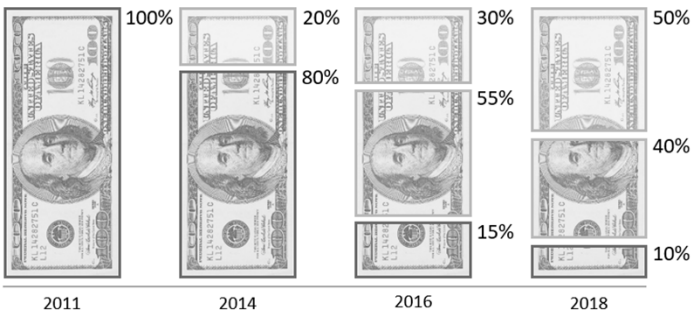
- CMS determines which models meet criteria for Advanced APMs.
- Qualifying APM Participants have a certain proportion of their Medicare payments or patients through the Advanced APM.
- Payment adjustment: Qualifying APM Participants will receive an annual 5% lump-sum bonus from 2019 through 2024. Beginning in 2026, they will receive higher physician fee-schedule updates, compounded annually.

APMs use quality measures similar to those of MIPS

15 https://oig.hhs.gov/oei/reports/oei-12-17-00350.pdf

Quality & Reimbursement

HHS seeks to reduce CMS fee-for-service payments to 10% by 2018[1]



Payments linked to quality or value through alternative payment models like ACOs or bundled payment arrangement[2]

Payment linked to quality or value through programs like Hospital Value Purchasing and Hospital Readmissions Reductions

Medicare fee-for-service payment tied to volume

Payment is partially linked to quality

16 www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html#

Measuring Quality

- How is quality measured?
  - Guidelines & measures
    - Many guidelines developed by professional medical organizations
    - Accepted and published by CMS
- Clinicians choose to report on 6 measures
  - Choose from > 200 measures
  - 80% measures are tailored to specialists

17 https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf

CPG Example: Quality Indicators for Colonoscopy

1. Appropriate indication

2. Informed consent is obtained, including specific discussion of risks associated with colonoscopy

3. Use of recommended post polypectomy and post cancer resection surveillance intervals

4. Use of recommended ulcerative colitis/Crohn's disease surveillance intervals

5. Documentation in the procedure note of the quality of the preparation

6. Cecal intubation rates (visualization of the cecum by notation of landmarks and photo documentation of landmarks should be present in every procedure)

7. Detection of adenomas in asymptomatic individuals (screening)

8. Withdrawal time: mean withdrawal time should be >6 minutes in colonoscopies with normal results performed in patients with intact anatomy

9. Biopsy specimens obtained in patients with chronic diarrhea

10. Number and distribution of biopsy samples in ulcerative colitis and Crohn's colitis surveillance.

11. Mucosally based pedunculated polyps and sessile polyps < 2 cm in size should be endoscopically resected or documentation of unresectability obtained

12. Incidence of perforation by procedure type (all indications vs screening) is measured

13. Incidence of post polypectomy bleeding is measured

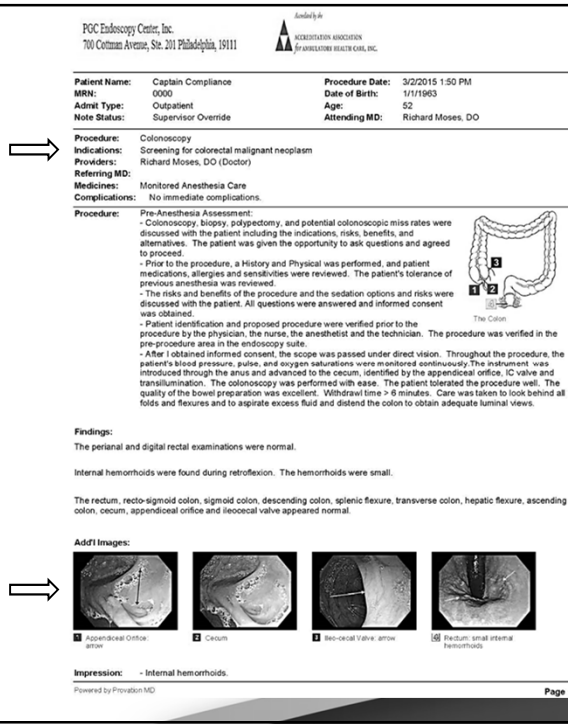
14. Post polypectomy bleeding managed non-operatively

18 Rex DK, et al. Am J Gastroenterol 2006;101:873–885.

Guidelines in Gastroenterology

Gastroenterology				
PQRS ID	**CMS E-Measure ID**	**Measure Title**	**Measure Type**	**High Priority**
47	NA	Care Plan	Process	Yes
128	69v5	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Process	No
130	68v6	Documentation of Current Medications in the Medical Record	Process	Yes
185	NA	Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	Process	Yes
226	138v5	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process	No
317	22v5	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:	Process	No
320	NA	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Process	Yes
343	NA	Screening Colonoscopy Adenoma Detection Rate Measure	Outcome	Yes
374	50v5	Closing the Referral Loop: Receipt of Specialist Report	Process	Yes
390	NA	Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options	Process	Yes
401	NA	Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis	Process	No
402	NA	Tobacco Use and Help with Quitting Among Adolescents	Process	No
431	NA	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Process	No

19



PGC Endoscopy Center, Inc.
700 Cottman Avenue, Ste. 201 Philadelphia, 19111

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Patient Name: Captain Compliance
MRN: 0000
Admit Type: Outpatient
Note Status: Supervisor Override
Procedure Date: 3/2/2015 1:50 PM
Date of Birth: 1/1/1963
Age: 52
Attending MD: Richard Moses, DO

Procedure: Colonoscopy
Indications: Screening for colorectal malignant neoplasm
Providers: Richard Moses, DO (Doctor)
Referring MD:
Medicines: Monitored Anesthesia Care
Complications: No immediate complications.

Procedure: Pre-Anesthesia Assessment:
- Colonoscopy, biopsy, polypectomy, and potential colonoscopic miss rates were discussed with the patient including the indications, risks, benefits, and alternatives. The patient was given the opportunity to ask questions and agreed to proceed.
- Prior to the procedure, a History and Physical was performed, and patient medications, allergies and sensitivities were reviewed. The patient's tolerance of previous anesthesia was reviewed.
- The risks and benefits of the procedure and the sedation options and risks were discussed with the patient. All questions were answered and informed consent was obtained.
- Patient identification and proposed procedure were verified prior to the procedure by the physician, the nurse, the anesthetist and the technician. The procedure was verified in the pre-procedure area in the endoscopy suite.
- After I obtained informed consent, the scope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously.The instrument was introduced through the anus and advanced to the cecum, identified by the appendiceal orifice, IC valve and transillumination. The colonoscopy was performed with ease. The patient tolerated the procedure well. The quality of the bowel preparation was excellent. Withdrawl time > 6 minutes. Care was taken to look behind all folds and flexures and to aspirate excess fluid and distend the colon to obtain adequate luminal views.

The Colon

Findings:

The perianal and digital rectal examinations were normal.

Internal hemorrhoids were found during retroflexion. The hemorrhoids were small.

The rectum, recto-sigmoid colon, sigmoid colon, descending colon, splenic flexure, transverse colon, hepatic flexure, ascending colon, cecum, appendiceal orifice and ileocecal valve appeared normal.

Add'l Images:

1 Appendiceal Orifice: arrow
2 Cecum
3 Ileo-cecal Valve: arrow
4 Rectum: small internal hemorrhoids

Impression: - Internal hemorrhoids.

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Page 1

20

PGC Endoscopy Center, Inc.
700 Cottman Avenue, Ste. 201 Philadelphia, 19111

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Patient Name:	Captain Compliance	**Procedure Date:**	3/2/2015 1:50 PM
MRN:	0000	**Date of Birth:**	1/1/1963
Admit Type:	Outpatient	**Age:**	52
Note Status:	Supervisor Override	**Attending MD:**	Richard Moses, DO

- The rectum, recto-sigmoid colon, sigmoid colon, descending colon, splenic flexure, transverse colon, hepatic flexure, ascending colon, cecum, appendiceal orifice and ileocecal valve are normal.
- No specimens collected.

Recommendation: - Discharge patient to home (ambulatory).
- Repeat colonoscopy in 10 years for screening purposes.
- Return to primary care physician as previously scheduled.

Procedure Code(s): --- Professional ---
G0121, Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

Diagnosis Code(s): --- Professional ---
V76.51, Special screening for malignant neoplasms of colon
455.0, Internal hemorrhoids without mention of complication

The codes documented in this report are preliminary and upon coder review may be revised to meet current compliance requirements.

Richard Moses, DO
3/2/2015 2:05:34 PM
Number of Addenda: 0
Note Initiated On: 3/2/2015 1:50:55 PM

21

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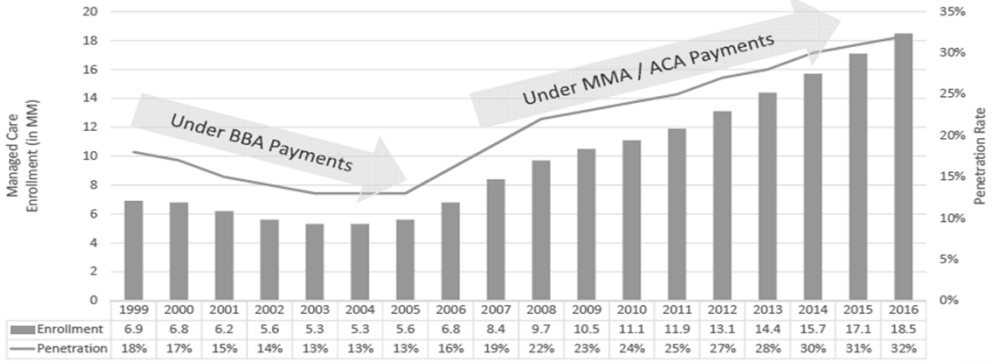
Improving Quality of Care

Quality and Cost Driver: Medicare Enrollment

Total Medicare Private Health Plan Enrollment, 1999-2016 (June)



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Enrollment	6.9	6.8	6.2	5.6	5.3	5.3	5.6	6.8	8.4	9.7	10.5	11.1	11.9	13.1	14.4	15.7	17.1	18.5
Penetration	18%	17%	15%	14%	13%	13%	13%	16%	19%	22%	23%	24%	25%	27%	28%	30%	31%	32%

Quality and Cost: Risk Adjustment, Quality Payments

The Future of Healthcare Reimbursement

Will pay for the treatment of diseases, not for office visits and procedures	• 50% risk adjustment by 2015
Will promote quality care through value based reimbursement	• 75% value based payments by 2020
Will put primary care physicians back in the driver seat	• 85% of codes that drive the RAF score are generated by primary care providers

Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change, both for ourselves and our country. http://www.hcttf.org/

RAF = Risk Adjustment Factor

ACO Quality and Cost: Measuring HCCs & RAFs

Risk Adjustment CMS - HCC:
Hierarchical Condition Category (HCC)

- The RAF score is calculated for each member by adding Hierarchical Condition Categories (HCCs)
- There are approximately ~9500 ICD-10-CM diagnoses that map to 79 Hierarchical Condition Categories (HCC)
- A coefficient or "weight" is assigned to each category of chronic complex diagnoses as well as severe acute diagnoses

HCC Category	Description Label	Coefficient
HCC01	HIV/AIDS	0.312
HCC02	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.455
HCC06	Opportunistic Infections	0.435
HCC08	Metastatic Cancer and Acute Leukemia	2.625
HCC09	Lung and Other Severe Cancers	0.970
HCC10	Lymphoma and Other Cancers	0.677
HCC11	Colorectal, Bladder, and Other Cancers	0.301
HCC12	Breast, Prostate, and Other Cancers and Tumors	0.146
HCC17	Diabetes with Acute Complications	0.318
HCC18	Diabetes with Chronic Complications	0.318
HCC19	Diabetes without Complication	0.104
HCC21	Protein-Calorie Malnutrition	0.545
HCC22	Morbid Obesity	0.273

Note: Coefficients shown are based on CMS HCC Model V22 – community, non-dual, aged

25

Health Plans, ACOs Paid Based On Risk and Quality

Risk Adjustment Factor (RAF) Financial Comparison

Sam Brown DOB 1/10/1931 Clinical picture: Diabetic CKD Stage 5, Chronic Diastolic CHF, Afib & RA

No Conditions Documented	
84 yr old Male – Non-dual aged	0.537
No RA documented	–
No Diabetes documented	–
No CKD stage 5 documented	–
No Chronic Diastolic CHF documented	–
No Chronic Atrial Fibrillation	–
No Disease Interaction	–
No Disease Interaction	–
No Disease Interaction	–
Total RAF: (Demographics and HCC)	0.537
PMPM Payment	$430
Annual Payment	$5,155

Conditions not documented to highest level of specificity or missing documentation	
84 yr old Male – Non-dual aged	0.537
RA M06.09 (HCC 40)	0.423
Type II Diabetes w/o compl. E11.9 (HCC 19)	0.104
No CKD stage 5 documented	–
No Chronic Diastolic CHF documented	–
No Chronic Atrial Fibrillation	–
No Disease Interaction	–
No Disease Interaction	–
No Disease Interaction	–
Total RAF: (Demographics and HCC)	1.064
PMPM Payment	$851
Annual Payment	$10,214

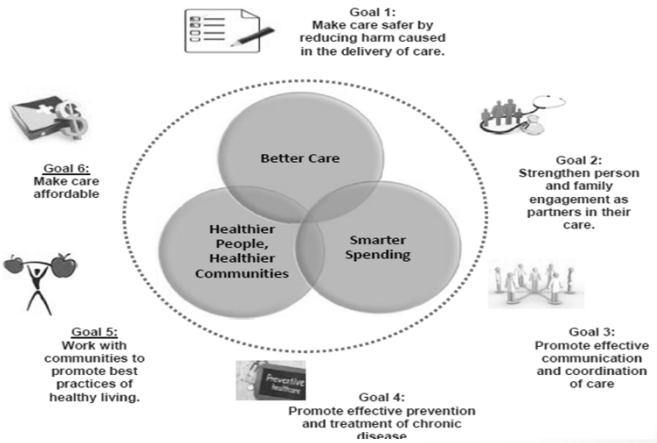
All conditions precisely documented	
84 yr old Male – Non-dual aged	0.537
RA M06.09 (HCC 40)	0.423
Type II Diabetes w/ Diabetic CKD E11.22 (HCC 18)	0.318
CKD Stage 5 N18.5 (HCC 136)	0.237
Chronic Diastolic CHF I150.32 (HCC 85)	0.323
Chronic Atrial Fibrillation I48.2 (HCC 96)	0.268
Disease Interaction (CHF and Renal Failure)	0.271
Disease Interaction (CHF and Diabetes)	0.154
Disease Interaction (CHF and Afib)	0.105
Total RAF: (Demographics and HCC)	2.636
PMPM Payment	$2,109
Annual Payment	$25,306

ILLUSTRATION, BASED ON FY 2017 $800/MONTH BASE RATE, NON-DUAL AGED BENEFICIARY

26

CMS: Improving Quality Aligns with Good Healthcare (and reduces cost)

Align Initiatives with the Practice of Medicine



Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html

27

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Summary & Conclusions

A Brave New (Quality) World

- The premise: Quality care is less expensive care
- CMS health plans are paid based on risk, quality, and cost
- Commercial payers are shifting to 100% risk based contracts
- Reducing clinical variability (standardization of the practice of medicine) is promoted using clinical practice guidelines
- Providers expected to measure potential beneficiary cost by capturing Hierarchial Coding Conditions which create RAFs for each beneficiary
- Health plans use HCC/RAF data to negotiate contracts/set rates for beneficiaries

Resources

- Quality Payment Program
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program MACRA-NPRM-Slides.pdf
- QPP Education and Assistance
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html
- QPP Final Rule 2018
  - https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf
  - https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf
  - https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-NPC-Slides.pdf

Resources

- Quality Payment Program Provider Site
  - https://qpp.cms.gov/
- Hospital Readmissions Reduction Program
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html
- Hospital Value Based Purchasing (VBP) Program
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html
- Hospital Acquired Condition (HAC) Reduction Program
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html

31

Resources

Quality Payment Program: Delivery system reform, Medicare Payment Reform and MACRA. The Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives website:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html

CMS Qualified Health Plan (QHP) Enrollee Experience Survey (QHP Enrollee Survey) website:

http://qhpcahps.cms.gov

National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)1 Compliance AuditTM website:

http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx

32

Resources

2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide

http://www.csscoperations.com/internet/archive/cssc3_archive.nsf/docsCat/CSSC~CSSC%20Operations~Risk%20Adjustment%20Processing%20System~Training?open&expand=1&navmenu=Risk^Adjustment^Processing^System||

ICD-10-CM The Official Guidelines for Coding and Reporting

- www.cdc.gov/nchs/icd/icd10cm.htm

CMS News and Resources:

http://cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10

ICD-10 CME modules developed by CMS and Medscape:

http://www.cms.gov/Medicare/Coding/ICD10/Downloads/MedscapeModulesAvailableonICD10.pdf

CMS MLN Matters

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html?redirect=/MLNMattersArticles

33

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Resources

AHA Coding Clinic

http://www.ahacentraloffice.org/

AAPC

https://www.aapc.com/

AHIMA

http://www.ahima.org/

34

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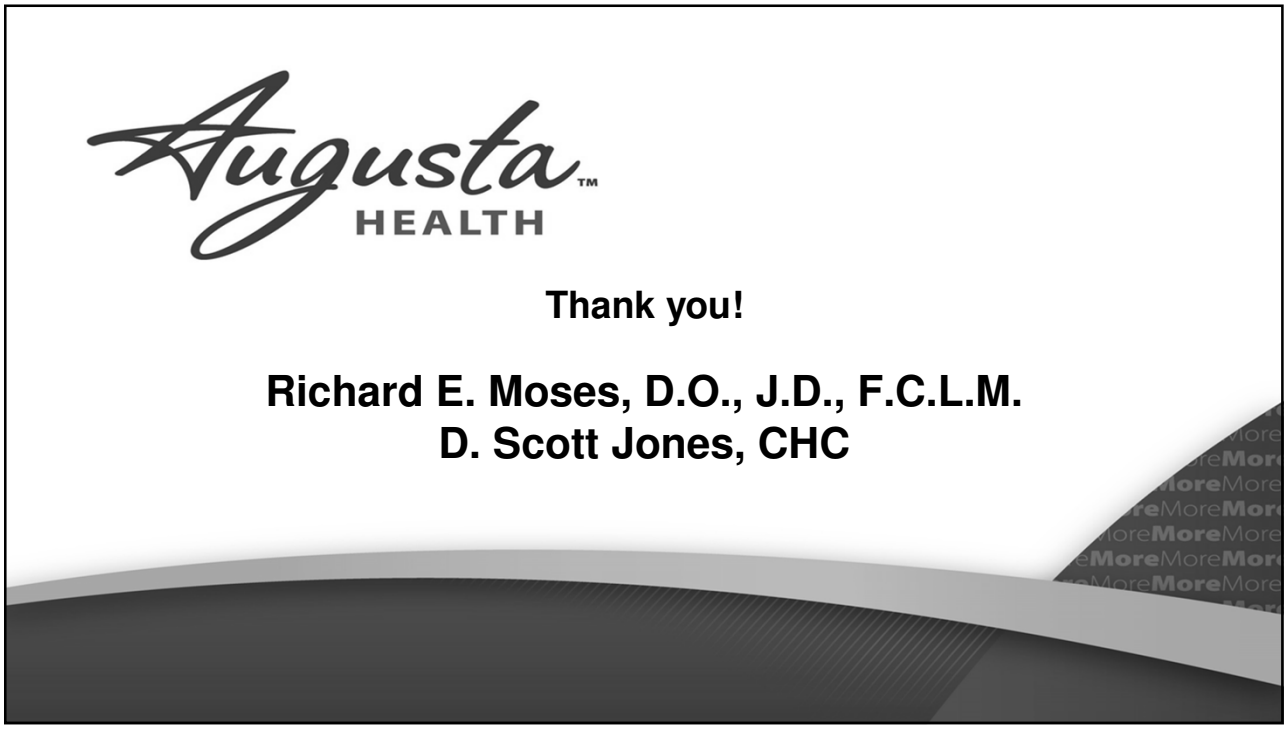
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HEALTH
Thank you!
Richard E. Moses, D.O., J.D., F.C.L.M.
D. Scott Jones, CHC