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
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)**


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?
QPP Training, Assistance, and Important Information


- **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](mailto:MIPS_VirtualGroups@cms.hhs.gov)

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
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

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
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%

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
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

APMs use quality measures similar to those of MIPS

Quality & Reimbursement

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

Payment is partially linked to quality
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

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

Guidelines in Gastroenterology

<table>
<thead>
<tr>
<th>PQR ID</th>
<th>CMS Measure ID</th>
<th>Measure Title</th>
<th>Measure Type</th>
<th>High Priority</th>
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<tbody>
<tr>
<td>47</td>
<td>NA</td>
<td>Care Plan</td>
<td>Process</td>
<td>Yes</td>
</tr>
<tr>
<td>128</td>
<td>69v5</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>Process</td>
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<tr>
<td>130</td>
<td>68v6</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Process</td>
<td>Yes</td>
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<tr>
<td>159</td>
<td>NA</td>
<td>Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use</td>
<td>Process</td>
<td>Yes</td>
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<tr>
<td>226</td>
<td>130v5</td>
<td>Preventive Care and Screening: Tobacco Use; Screening and Cessation Intervention</td>
<td>Process</td>
<td>No</td>
</tr>
<tr>
<td>317</td>
<td>22v5</td>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
<td>Process</td>
<td>No</td>
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<tr>
<td>320</td>
<td>NA</td>
<td>Appropriateness Colorectal Screening for Normal Colonoscopy in Average Risk Patients</td>
<td>Process</td>
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<tr>
<td>343</td>
<td>NA</td>
<td>Screening Colonoscopy Adenoma Detection Rate Measurement</td>
<td>Outcome</td>
<td>Yes</td>
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<tr>
<td>374</td>
<td>50v5</td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
<td>Process</td>
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<tr>
<td>390</td>
<td>NA</td>
<td>Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options</td>
<td>Process</td>
<td>Yes</td>
</tr>
<tr>
<td>401</td>
<td>NA</td>
<td>Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis</td>
<td>Process</td>
<td>No</td>
</tr>
<tr>
<td>402</td>
<td>NA</td>
<td>Tobacco Use and Help with Quitting Among Adolescents</td>
<td>Process</td>
<td>No</td>
</tr>
<tr>
<td>431</td>
<td>NA</td>
<td>Preventive Care and Screening: Unhealthy Alcohol Use; Screening &amp; Brief Counseling</td>
<td>Process</td>
<td>No</td>
</tr>
</tbody>
</table>
Improving Quality of Care
**Quality and Cost Driver: Medicare Enrollment**

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

**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.ncttf.org/](http://www.ncttf.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

<table>
<thead>
<tr>
<th>HCC Category</th>
<th>Description Label</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC01</td>
<td>HIV/AIDS</td>
<td>0.312</td>
</tr>
<tr>
<td>HCC02</td>
<td>Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock</td>
<td>0.455</td>
</tr>
<tr>
<td>HCC06</td>
<td>Opportunistic Infections</td>
<td>0.435</td>
</tr>
<tr>
<td>HCC09</td>
<td>Metastatic Cancer and Acute Leukaemia</td>
<td>2.625</td>
</tr>
<tr>
<td>HCC09</td>
<td>Lung and Other Severe Cancers</td>
<td>0.970</td>
</tr>
<tr>
<td>HCC10</td>
<td>Lymphoma and Other Cancers</td>
<td>0.677</td>
</tr>
<tr>
<td>HCC11</td>
<td>Colorectal, Bladder, and Other Cancers</td>
<td>0.501</td>
</tr>
<tr>
<td>HCC12</td>
<td>Breast, Prostate, and Other Cancers and Tumors</td>
<td>0.146</td>
</tr>
<tr>
<td>HCC17</td>
<td>Diabetes with Acute Complications</td>
<td>0.318</td>
</tr>
<tr>
<td>HCC18</td>
<td>Diabetes with Chronic Complications</td>
<td>0.318</td>
</tr>
<tr>
<td>HCC19</td>
<td>Diabetes without Complications</td>
<td>0.104</td>
</tr>
<tr>
<td>HCC21</td>
<td>Protein-Calorie Malnutrition</td>
<td>0.545</td>
</tr>
<tr>
<td>HCC22</td>
<td>Morbid Obesity</td>
<td>0.273</td>
</tr>
</tbody>
</table>

Note: Coefficients shown are based on CMS HCC Model V82 – community, non-dual aged

Health Plans, ACOs Paid Based On Risk and Quality

Risk Adjustment Factor (RAF) Financial Comparison

<table>
<thead>
<tr>
<th>No Conditions Documented</th>
<th>Conditions not documented to highest level of specificity or missing documentation</th>
<th>All conditions precisely documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 yr old Male - Non-dual aged</td>
<td>0.557</td>
<td>0.557</td>
</tr>
<tr>
<td>No RA documented</td>
<td>–</td>
<td>0.423</td>
</tr>
<tr>
<td>No Diabetes documented</td>
<td>–</td>
<td>0.104</td>
</tr>
<tr>
<td>No CKD stage 3 documented</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>No Chronic Diastolic CHF documented</td>
<td>–</td>
<td>0.257</td>
</tr>
<tr>
<td>No Chronic Atrial Fibrillation</td>
<td>–</td>
<td>0.323</td>
</tr>
<tr>
<td>No Disease Interaction</td>
<td>–</td>
<td>0.268</td>
</tr>
<tr>
<td>No Disease Interaction</td>
<td>–</td>
<td>0.271</td>
</tr>
<tr>
<td>No Disease Interaction</td>
<td>–</td>
<td>0.164</td>
</tr>
<tr>
<td>No Disease Interaction</td>
<td>–</td>
<td>0.165</td>
</tr>
<tr>
<td>No Disease Interaction</td>
<td>–</td>
<td>2.636</td>
</tr>
<tr>
<td>Total RAF: (Demographics and HCC)</td>
<td>0.557</td>
<td>1.064</td>
</tr>
<tr>
<td>PMPM Payment</td>
<td>$470</td>
<td>$891</td>
</tr>
<tr>
<td>Annual Payment</td>
<td>$5,199</td>
<td>$10,314</td>
</tr>
</tbody>
</table>

ILLUSTRATION: BASED ON FY 2017 $800/MONTH BASE RATE, NON-DUAL AGED BENEFICIARY
CMS: Improving Quality Aligns with Good Healthcare (and reduces cost)

Align Initiatives with the Practice of Medicine

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
- QPP Education and Assistance
- QPP Final Rule 2018
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
Resources

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

ICD-10-CM The Official Guidelines for Coding and Reporting
- www.cdc.gov/nchs/icd/icd10cm.htm

CMS News and Resources:

ICD-10 CME modules developed by CMS and Medscape:

CMS MLN Matters

Resources

AHA Coding Clinic
http://www.ahacentraloffice.org/

AAPC
https://www.aapc.com/

AHIMA
http://www.ahima.org/
Thank you!

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