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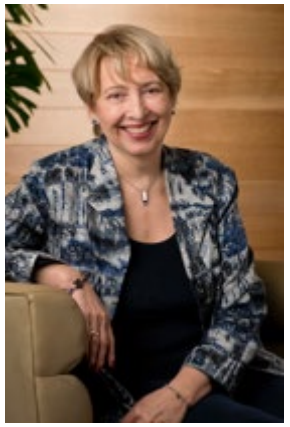
MIPS TIPS FOR SUCCESS: PREPARING FOR EPISODIC PAYMENTS

Presenters:
- Cathie Biga, MSN, FACC
- Claudia Vasquez, MSHCPM

Moderator:
- Nicole Knight, LPN, CPC, CCS-P

PRESENTERS



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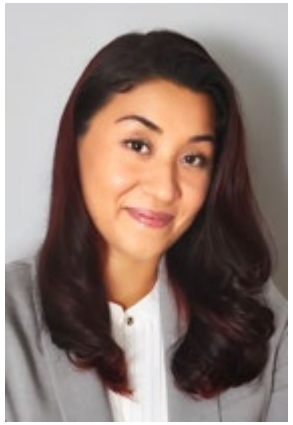
President/CEO, Cardiovascular Management of Illinois; Chairman, MedAxiom Board of Managers; Trustee, ACC



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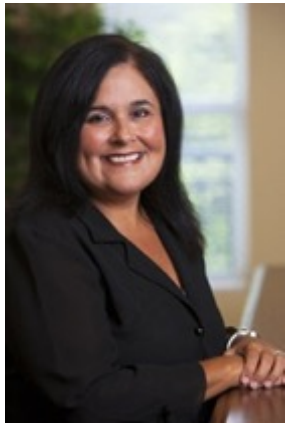

MODERATOR:
Nicole Knight, LPN, CPC, CCS-P
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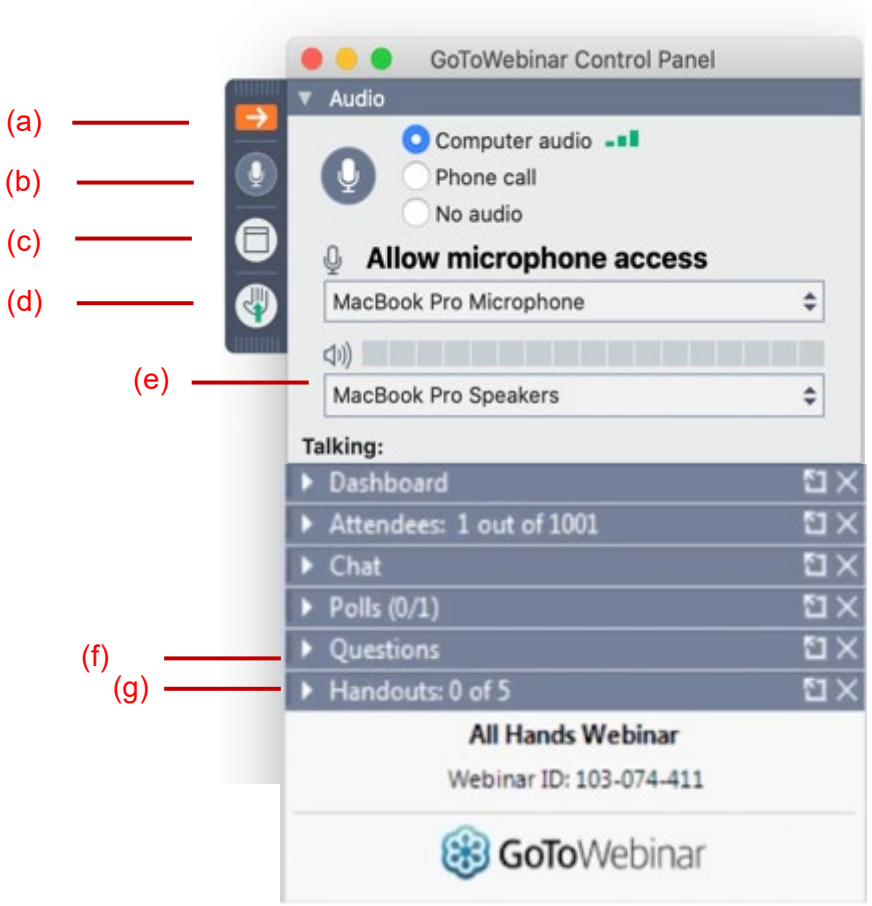
CONTROL PANEL



(a) - Grab Tab – click arrow to open/close Control Panel.

(b) - Mute – By default, attendees are muted (in listen-only mode) to minimize background noises.

(c) - View in **full screen mode**

(d) - Raise Hand – When vocal questions/comments are allowed, please select the hand icon to get the presenter's attention. A red arrow means your hand is raised.

(e) - Audio Pane – You can choose Computer Audio or Phone Call.

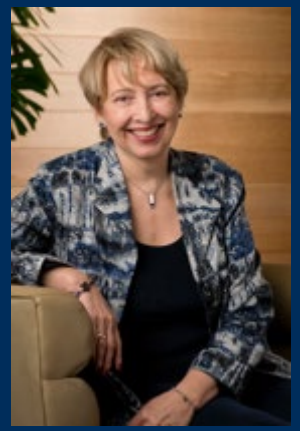
(f) - Questions Pane – Attendees can ask Questions to organizers during a session. Broadcast messages to attendees will also show here.

(g) - Handouts – Organizers can share handouts during webinars. Handouts are made available in the Control Panel during the session, which attendees can then download onto their own devices.

AGENDA

- Quality Payment Program
- Attribution Methodology
- Q&A

QUALITY PAYMENT PROGRAM



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DISCLOSURES

no disclosures

CB: no disclosures

TERMINOLOGY LEVEL-SETTING

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MACRA

Medicare Access and CHIP Reauthorization Act of 2015

- MIPS: Merit-based Incentive Payment System
- APM: Alternative Payment Models

QPP

Quality Payment Program

- Began January 1, 2017
- Comprises MIPS and Advanced APM (AAPM) pathways

HOW MIPS PAYMENTS ARE CALCULATED

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Quality

Cost

Improvement Activities

Promoting Interoperability

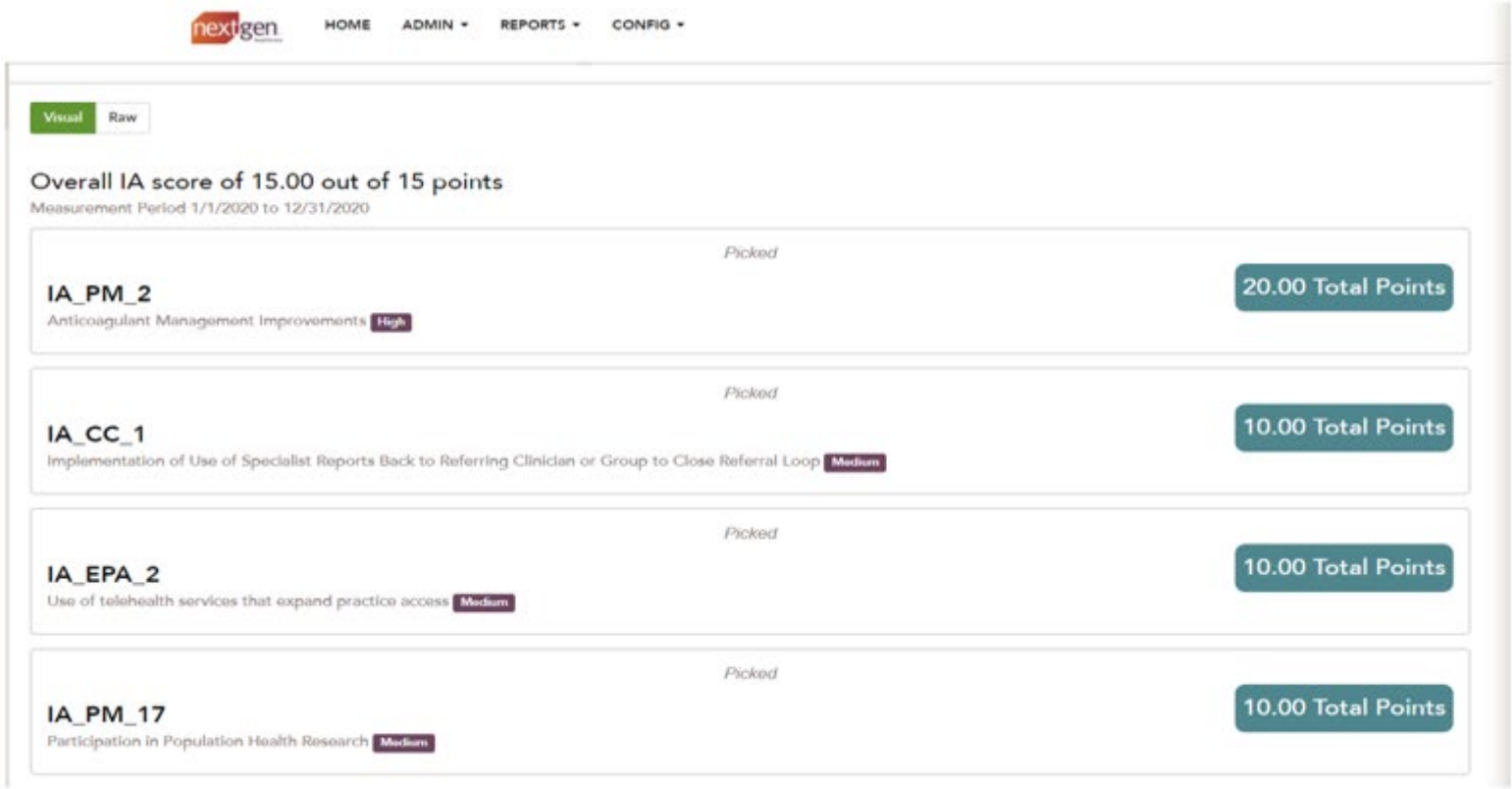
2020 SCORES ARE AVAILABLE

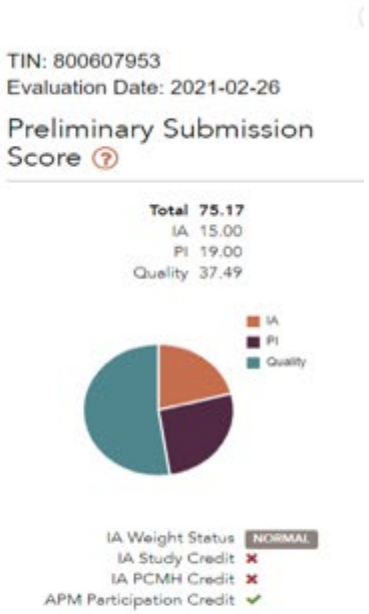
MIPS Scores for 2020	Actual Points	Possible Points
Improvement Activities	15.00	15
Promoting Interoperability	19.00	25
Quality	37.49	45
*** Quality data was also submitted through ACC Pinnacle Registry and score was 43.15		

Submit via different "vehicles" – CMS will take the best score…

IMPROVEMENT ACTIVITIES

Improvement Activities:





Remember to save supporting information for possible audits

SOLID DOCUMENTATION IS CRITICAL

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South – IA Documentation of Measures for 2020

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Validation	Suggested Documentation (inclusive of dates during the selected continuous 90 day or year long reporting period)	First PY	Examples of Additional Activities that Qualify for Attestation
IA_EPA_2	Expanded Practice Access	Use of telehealth services that expand practice access	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleaudiology pilots that assess ability to still deliver quality care to patients.	Medium	Documented use of telehealth services and participation in data analysis assessing provision of quality care with those services NOTE: For the purposes of this IA, telehealth services include a "real time" interaction and may be obtained over the phone, online, etc. and are not limited to the Medicare reimbursed telehealth service criteria.	1) Use of Telehealth Services - Documented use of telehealth services through: a) claims adjudication (may use G codes to validate); b) EHR or c) other medical record document showing specific telehealth services, consults, or referrals performed for a patient; and 2) Analysis of Assessing Ability to Deliver Quality of Care - Participation in or performance of quality improvement analysis showing delivery of quality care to patients through the telehealth medium (e.g. Excel spreadsheet, Word document or others). NOTE: For the purposes of this IA, telehealth services include a "real time" interaction and may be obtained over the phone, online, etc. and are not limited to the Medicare reimbursed telehealth service criteria.	2017	

In 2020, with changes in Telehealth regulations, our Physicians offered Telehealth and Phone Consultation Visits when the COVID-19 Pandemic started, to minimize exposure in the office. They continue to offer these Telehealth visits for patient convenience. The South practice scheduled 5,160 Telehealth Visits in 2020 which 4,661 were kept appts. Telehealth visits included patients who would normally be seen in the office or in a nursing home. Many patients were concerned about coming into the office or hospital to see the Cardiologist due to COVID-19, so this prevented patients from cancelling their appts and allowed for an assessment until their next scheduled visit.

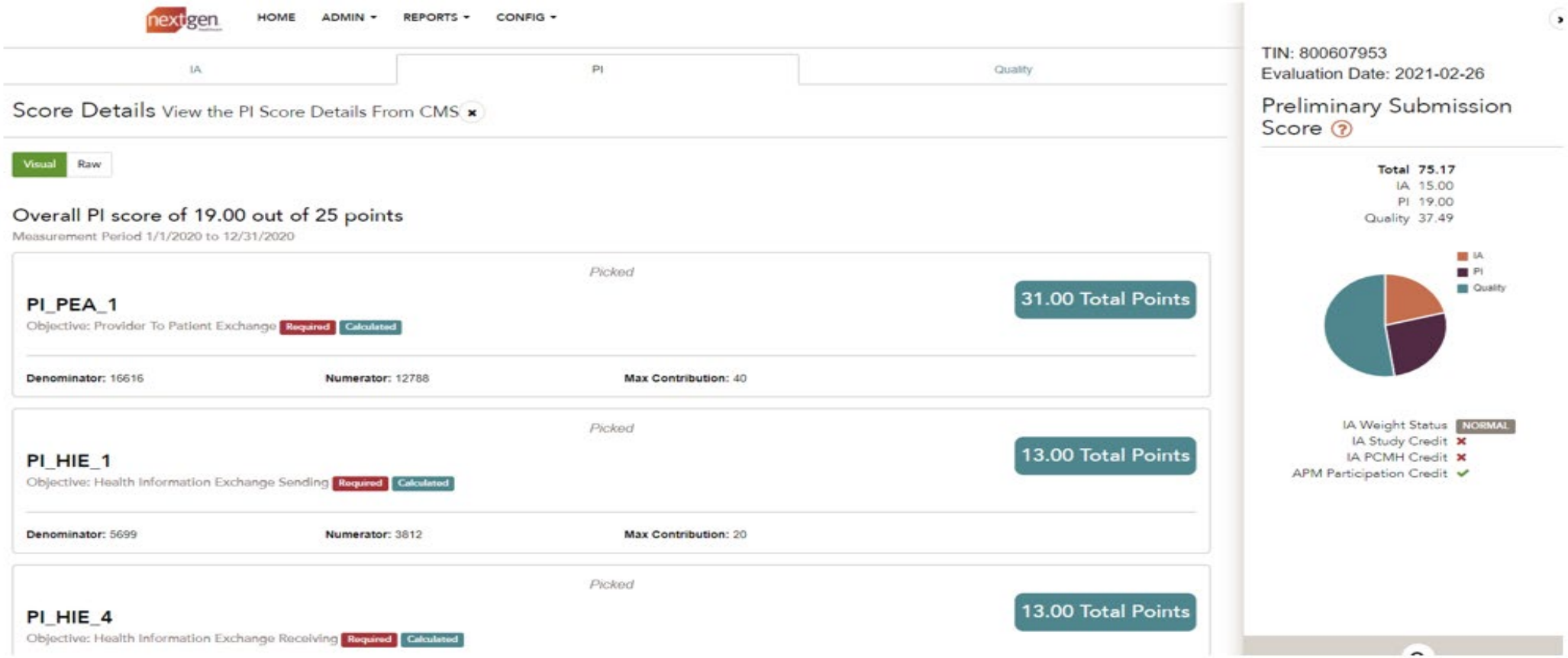
We created a new custom template in NextGen EMR to document and bill phone consultations. We modified existing templates in NextGen EMR to document and bill Video Telehealth visits. The templates had to be customized by payer to submit correct billing codes and place of service. We customized documents in Nextgen so that the Telehealth consent was included in documentation and the visit could be identified as a Phone Consultation or Video Telehealth visit.

See reports called 'South- Telehealth Visits for 2020 Appts' and 'South-Telehealth Visits for 2020 Charges' and 'South – Phone Comm Visits 2020 Charges' for details on charges and scheduled appointments.

We also have a custom report that runs daily to show upcoming appointments for the next day. The report breaks down phone consultation, video telehealth and in person visits per schedule. See report called 'South-Appt_Types Telehealth 2020' for details. Below is an example of the report for one day.

PROMOTING INTEROPERABILITY

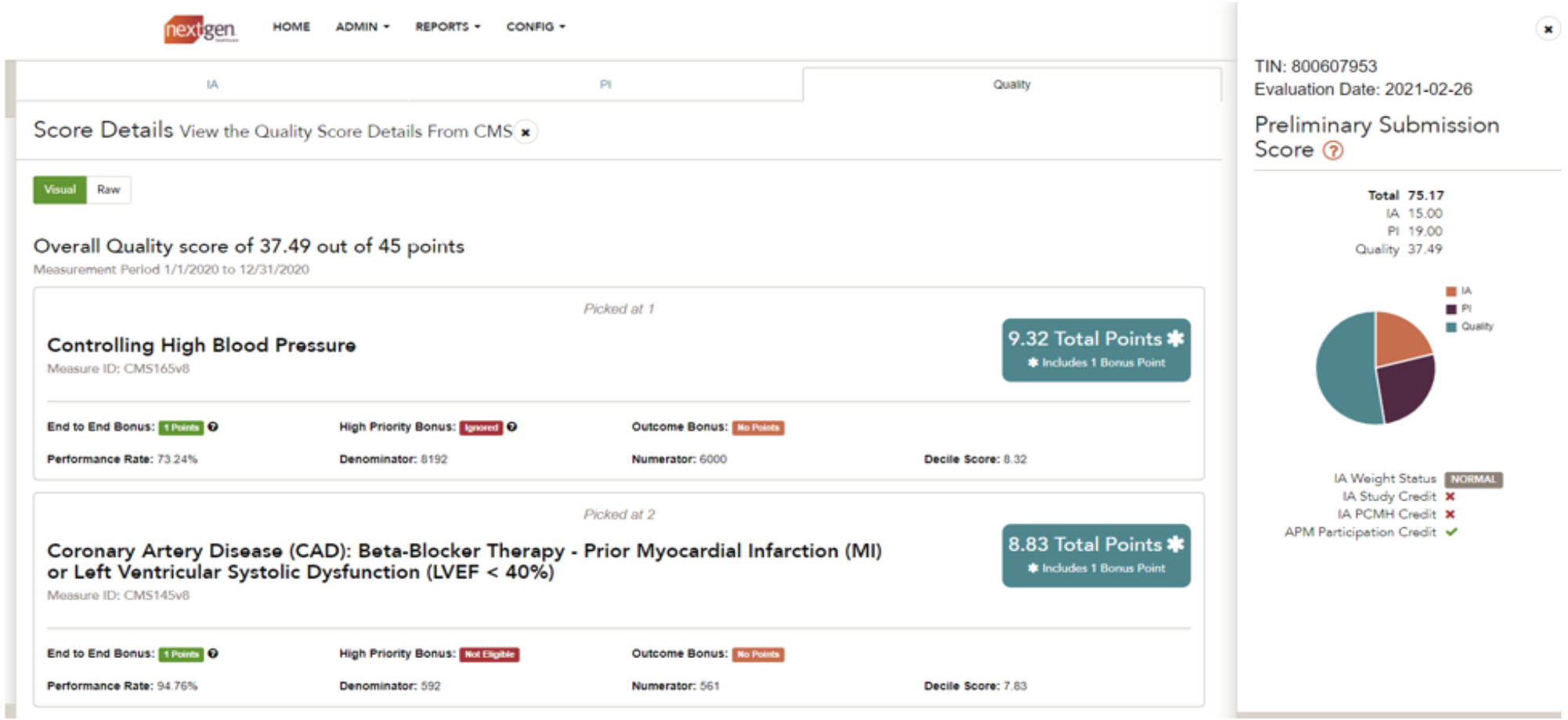
Promoting Interoperability:



Portals and the use of telehealth…

QUALITY

Quality:



HOW 2023 MIPS PAYMENTS WILL BE CALCULATED

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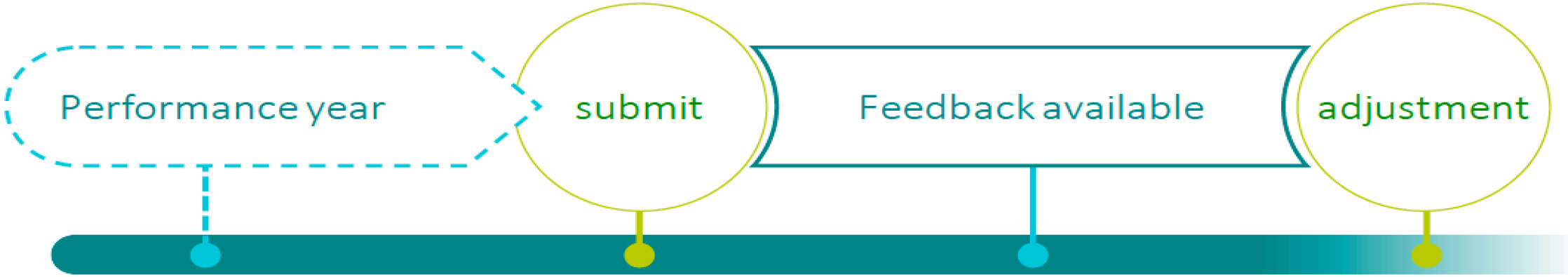

2021
Performance Year

- Performance year opens January 1, 2021
- Closes December 31, 2021
- Clinicians care for patients and record data during the year

2022
Data Submission

- Data submission opens January 4, 2022
- Deadline for submitting data is March 31, 2022
- Clinicians are encouraged to submit data early

2022
Feedback

- CMS provides performance feedback after the data is submitted
- Clinicians will receive feedback before the start of the payment year

2023
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2023

HOW MIPS PAYMENTS ARE CALCULATED

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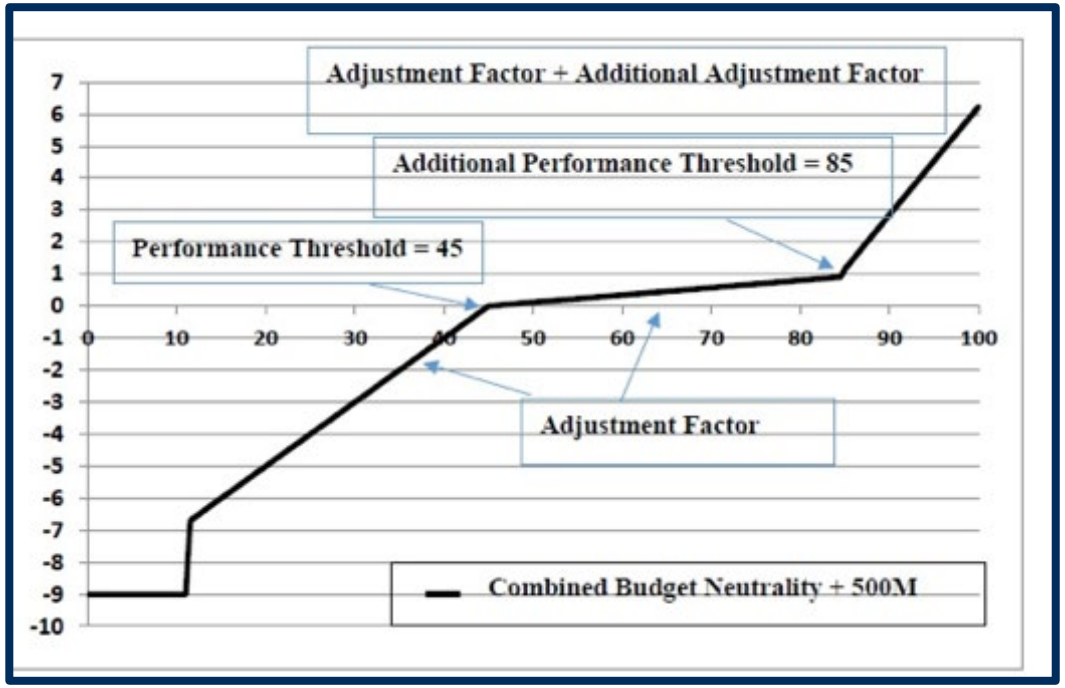
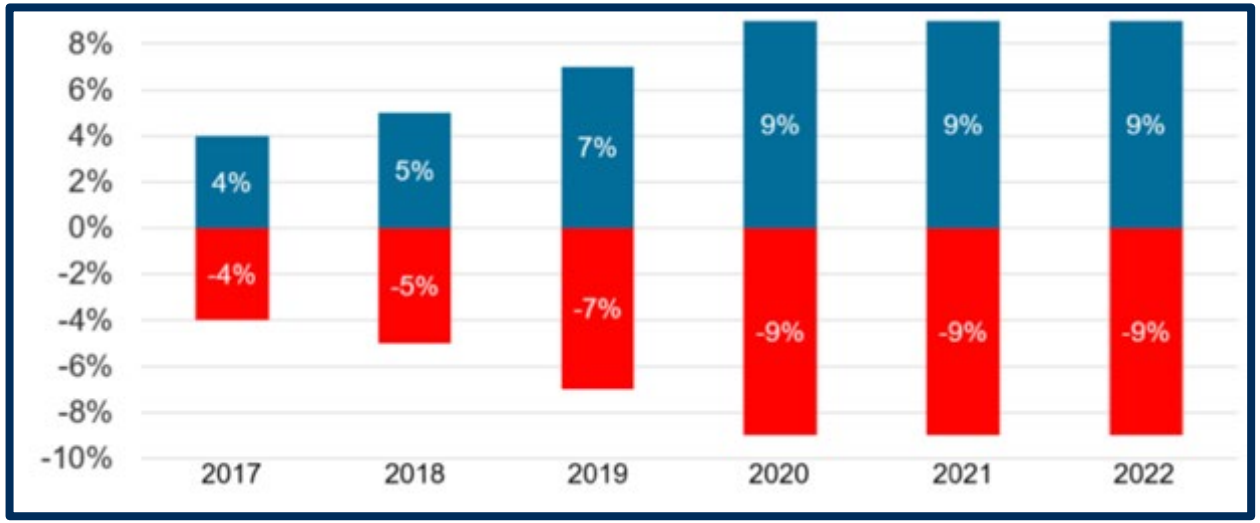
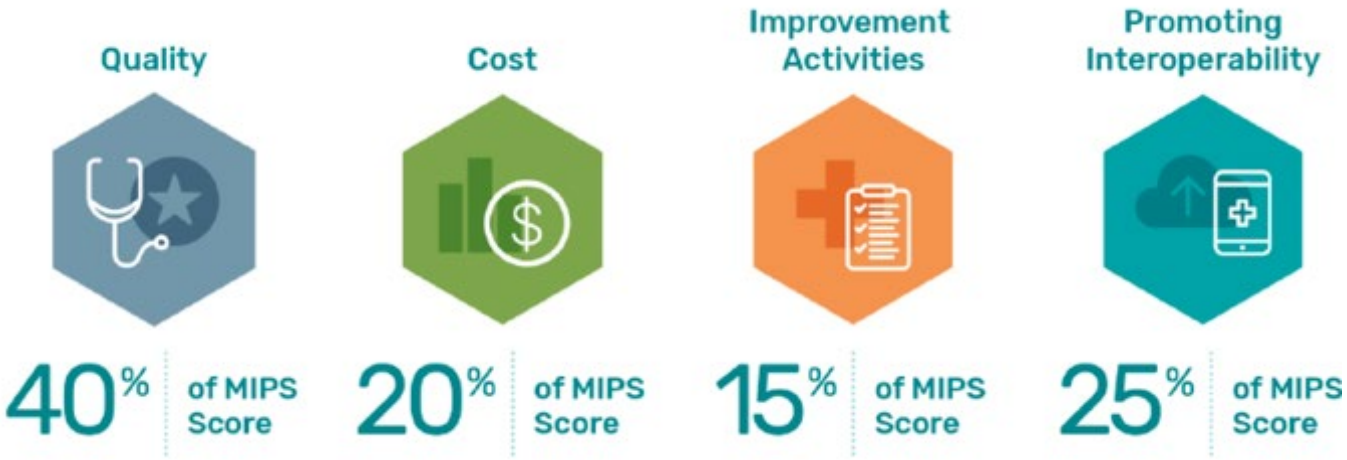
Performance Year: 2020 → Payment Year: 2022





HOW 2023 MIPS PAYMENTS WILL BE CALCULATED



PERFORMANCE THRESHOLD

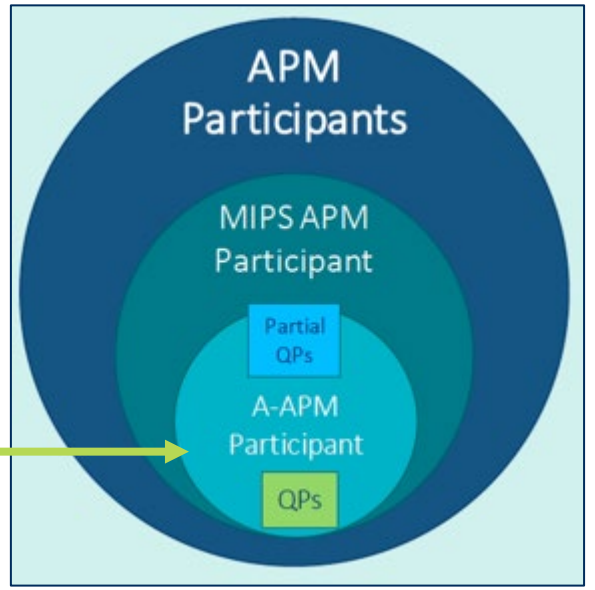
For 2021 the performance threshold will be set at 60 points, exceptional performance at 85 points. The 2022 performance period/2024 payment year will be the final year of the additional positive adjustment for exceptional performance.

209 QUALITY MEASURES FOR 2021

Federal Register Dec 2020

beginning pg. 1821

HOW DOES IT ALL WORK?



AAPM 2019
195,564 clinicians
5% adjustment

MIPS 2019
538,186 clinicians
Exceptional Performance: **74.00**%
(73.83% in 2018)
Below Threshold: 0.55%

MIPS APM 2019
416,281 clinicians
Exceptional Performance: **95.88**%
(99.60% in 2018)
Below Threshold: 0.04%

APM PERFORMANCE PATHWAY (APP)

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Comprises a fixed set of measures for each performance category:

QUALITY	IMPROVEMENT ACTIVITY	PROMOTING INTEROPERABILITY	COST
Quality = 50% • Required MSSP quality determinations for ACOs • CAHPS + 2 claims-based + 3 eCQMs • In 2021, ACOs can report 10 CMS Web Interface measures (sunsets 2022)	**Improvement Activity = 20%** • Full credit (by virtue of being in an APM)	**Promoting Interoperability = 30%** • Scored like MIPS	**Cost = 0%** • Because cost control inherent in APM

QUALITY MEASURES IN APP

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID # 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient's Experience
Quality ID # 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID # 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID # 236	Controlling High Blood Pressure	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Measure # TBD	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Measure # TBD	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A	Admissions & Readmissions

THE 6 APP QUALITY MEASURES

1 - CAHPS

2 - Admin Claims-based

3 - eCQM

QPP FINAL RULE 2021

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PROMOTING INTEROPERABILITY

Health Information Exchange (HIE) Bi-directional Exchange Measure

We are proposing to add a **Health Information Exchange (HIE) Bi-directional Exchange measure**, which would be:

- Worth 40 points
- An optional alternative to the 2 existing measures - clinicians may report either the new HIE measure OR the 2 existing measures
- Reported by attestation with a yes/no response:

> - *I participate in an HIE to enable secure, bi-directional exchange to occur for every patient encounter, for every patient transition or referral, and record stored or maintained in the EHR during the performance period.*
> - *The HIE that I participate in is capable of exchanging information across broad network of unaffiliated exchange partners including those using disparate electronic health records (EHRs); and does not engage in exclusionary behavior when determining exchange partners.*
> - *I use the functions of Certified EHR Technology (CEHRT) for this measure, which may include technology certified to criteria at 45 CFR 170.315(b)(1), (b)(2), (g)(8), or (g)(10).*

QUALITY MEASURES IN APP

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Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID#: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third-Party Intermediary	Patient's Experience
Quality ID#: 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Quality ID#: 480	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A	Admissions & Readmissions
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third-Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third-Party Intermediary	Treatment of Mental Health
Quality ID#: 236	Controlling High Blood Pressure	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third-Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 318	Falls: Screening for Future Fall Risk	CMS Web Interface*	APM Entity/Third-Party Intermediary	Preventable Healthcare Harm
Quality ID#: 110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface*	APM Entity/Third-Party Intermediary	Preventive Care
Quality ID#: 226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface*	APM Entity/Third-Party Intermediary	Prevention and Treatment of Opioid
Quality ID#: 113	Colorectal Cancer Screening	CMS Web Interface*	APM Entity/Third-Party Intermediary	Preventive Care
Quality ID#: 112	Breast Cancer Screening	CMS Web Interface*	APM Entity/Third-Party Intermediary	Preventive Care
Quality ID#: 438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface*	APM Entity/Third-Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 370	Depression Remission at Twelve Months	CMS Web Interface*	APM Entity/Third-Party Intermediary	Treatment of Mental Health

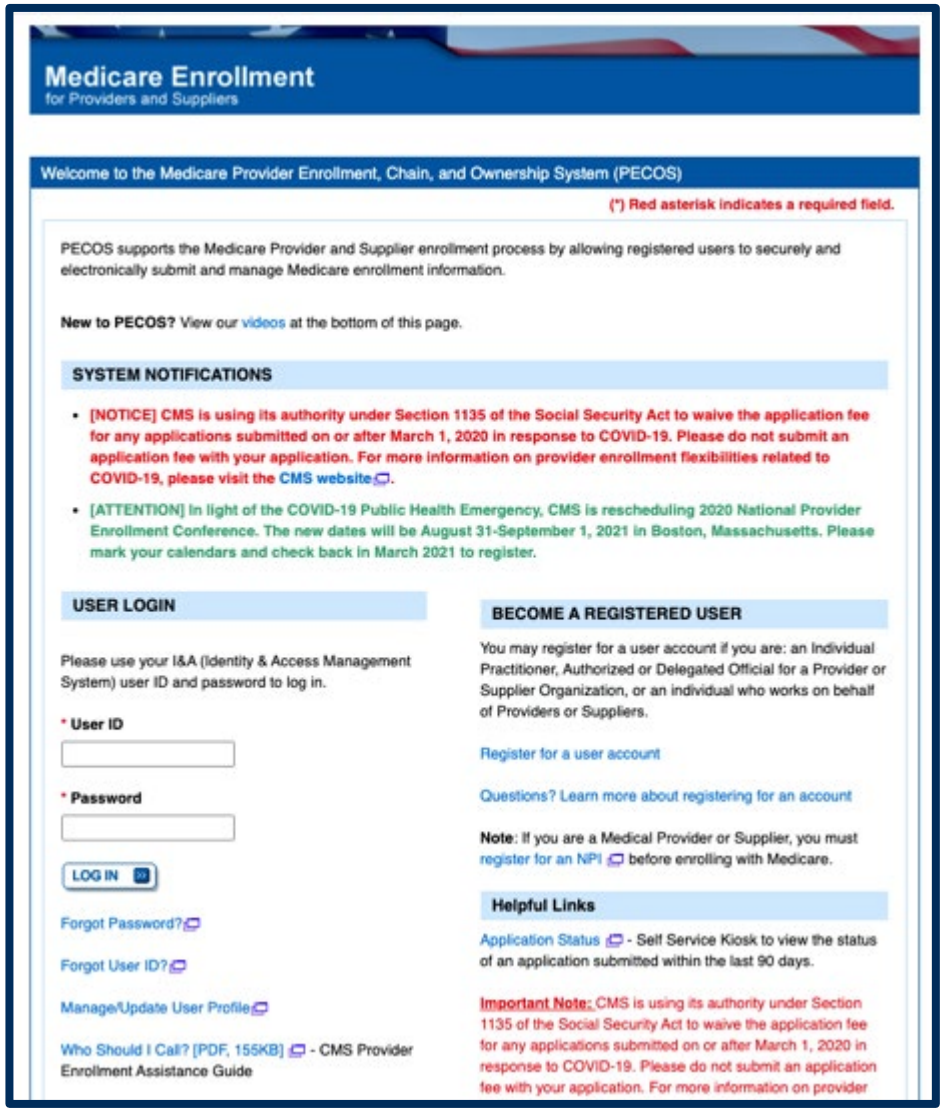
THE 13 APP QUALITY MEASURES

1 – CAHPS
2 – Admin Claims-based
10 – CMS Web interface

TRANSITIONING TO COST

PECOS

Provider
Enrollment,
Chain, and
Ownership
System



COST AND 2021

20% of the total MIPS score – and it will be going up in 2022 and 2023

- Clinicians reporting under APM's Performance Pathway are not scored on cost

Cost is based on Medicare Part A & B *claims* data

- Total Per Capita Cost (TPCC)
- Medicare Spend Per Beneficiary (MSPB)

Episodes

- Need ≥10 or ≥20 attributed cases for each of the 18 episodes to "count"

COST PERFORMANCE CATEGORY MEASURES

There are 21 total cost measures for the 2021 performance period.

- Total Per Capita Cost (TPCC)
- Medicare Spending Per Beneficiary Clinician (MSPB Clinician)
- 13 Procedural episode-based measures and 5 acute inpatient medical condition episode-based measures (18 measures total)

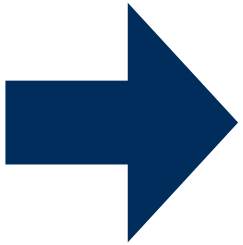
TOTAL PER CAPITA COST: TPCC

- Reevaluated in 2018 and implemented changes in 2020
- Risk adjusted
- 20 patients attributed in order to “Count” in the 20 cost measures
- Attribution revised to account for primary care relationships
  - Costs assigned to clinician AFTER the relationship is established

TPCC MEASURE ATTRIBUTION

Attribution is a combination of

1) E/M Primary Care Service
2) General Primary Care Service or 2nd E/M Service



- The “candidate event” triggers the start of a risk window that continues until one year after that date
- Multiple candidate events can occur within a performance year
- A patient’s costs are attributable to a clinician during months where the risk window and performance year overlap.

CANDIDATE EVENT

The TPCC attribution begins with a “candidate event,’ or services triggering the start of the primary care relationship.

Clinician bills an initial E/M primary care service

AND

Any clinician bills another primary care service **within 3 days**

OR

A clinician from the same TIN bills a second E&M primary care service or another primary care service **within 90 days**

MEDICARE SPEND PER BENEFICIARY: MSPB

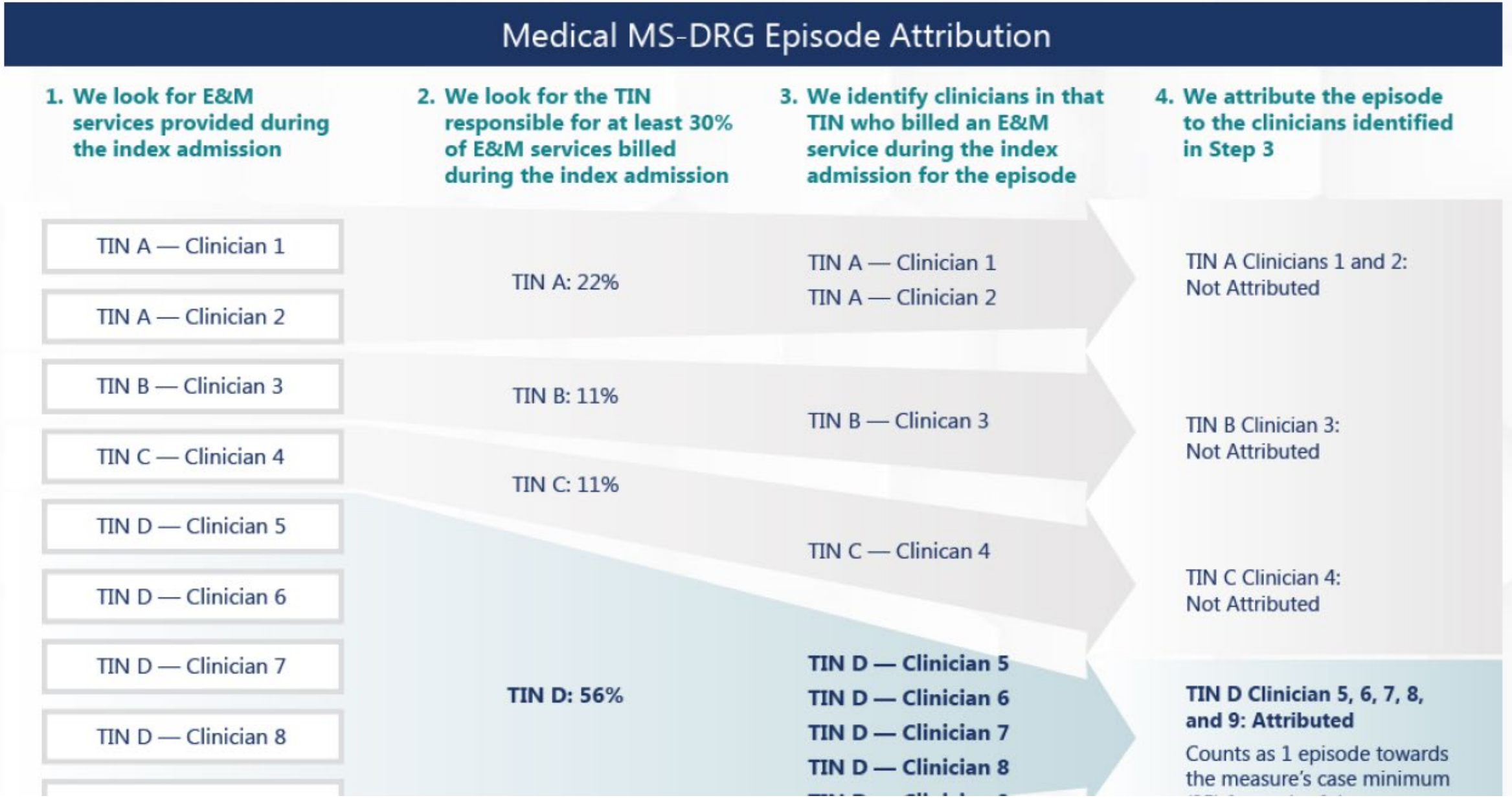
- 3 days prior to and 30 days post hospitalization

- Medical DRG attribution:
  - TIN that billed 30% of inpatient E&M
  - Any TIN/NPI that 1 E&M in that 30%

- Attribution revised for 2020 PY
  - MSPB Attributed to TIN first then NPI
  - Medical (need 20 cases) and procedural (need 10 cases) attribution
  - Remove services where services rendered do not influence clinician

- Surgical/Procedural attribution: TIN that performed the main procedure

Medical MS-DRG Episode Attribution



Surgical Episode Attribution Example

1. We identify TINs and Clinicians who billed CPT/HCPCS codes during Index Admission for a surgical episode	2. We identify TINs and Clinicians that billed relevant CPT/HCPCS codes for the surgical episode	3. We attribute the episode to the TIN(s) and clinician(s) identified in step 2
TIN A — Clinician 1	**TIN A: Yes**	**TIN A: Attributed**
TIN A — Clinician 2	**Clinician 1: Yes**	**Clinician 1: Attributed**
	Clinician 2: No	Clinician 2: Not Attributed
TIN B — Clinician 3	TIN B: No	TIN B: Not Attributed
TIN C — Clinician 4	Clinician 3: No	Clinician 3: Not Attributed
TIN C — Clinician 5	TIN C: No	TIN C: Not Attributed
TIN C — Clinician 6	Clinician 4: No	Clinician 4: Not Attributed
	Clinician 5: No	Clinician 5: Not Attributed
	Clinician 6: No	Clinician 6: Not Attributed

EPISODE-BASED MEASURE ATTRIBUTION

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Acute Inpatient Episodes

- First attributed to the TIN billing at least 30%of inpatient E/M services on Part B physician/supplier claims during the inpatient stay.
- Then attributed to any clinician in that TIN who billed at least one inpatient E/M service during the inpatient stay.

Procedural Episodes

Attribute the episode to any clinician who bills the code that triggers the episode.

MIPS AND COVID

Basics:

- *No changes* to existing measures:
  - TPCC measure
  - MSPB Clinician measure
  - 18 episode-based cost measures
- *No changes* to measure attribution
- *Proposed:* updating measure specifications to include telehealth services

Measures:

2020 Final	2021 Proposed
Measures: • Total Per Capita Cost (TPCC) measure (Revised) • Medicare Spending Per Beneficiary - Clinician (MSPB-C) measure (Name and specification Revised) • 8 existing episode-based measures • Added 10 new episode-based measures	• Adding telehealth services directly applicable to existing episode-based cost measures and TPCC measure • Updated specifications available for review on the MACRA feedback page

HOW DO THEY CALCULATE COST MEASURES?

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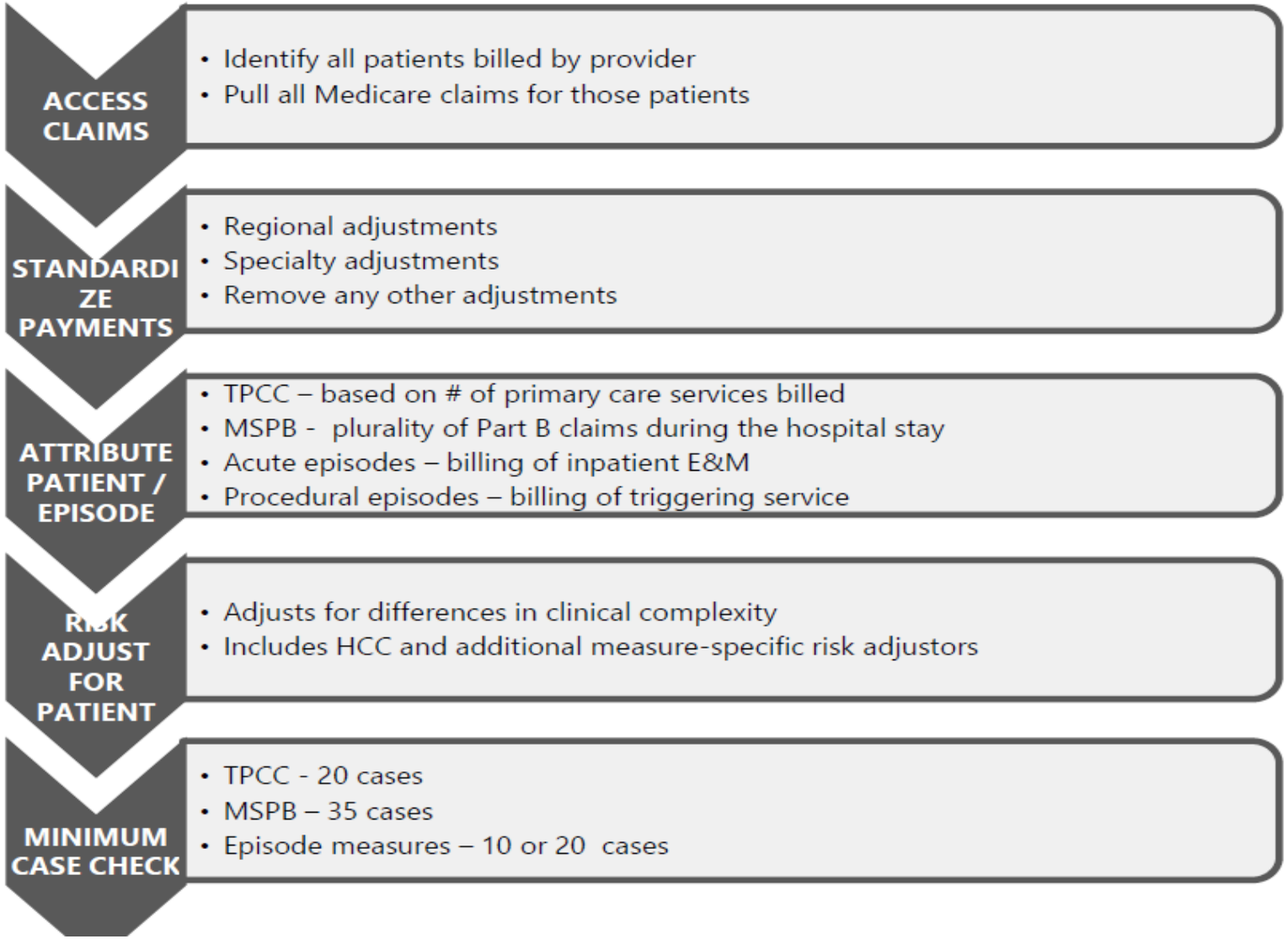

MIPS AND BUNDLES

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Remember! BPCI-A ends 12/23…episodes WILL be in our future

- 8 episodes in 2019 (PCI, Revasc, CABG, STEMI/PCI)
- 6 more field tested in 2020 for 2022 (diabetes, asthma, sepsis)
- 10 new added in 2020 (field tested in 2018) (added pneumonia, COPD)

Episode-based measures (18 measures)	Assess the cost of care that is clinically related to initial treatment of a patient and provided during an episode's time frame	√ Payment standardized √ Risk adjusted	20 episodes for acute inpatient measures 10 episodes for procedural measures	Medicare Part A & B claims

NEW FIELD-TESTED EPISODES RELEASED

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Historical FTE: 8 in phase 1 (2019/2020) and 11 in phase 2 (2020)

Phase 3 will be implemented in 2022

- ✓ COPD
- ✓ Diabetes
- ✓ Sepsis
- ✓ Melanoma Resection
- ✓ Colon & Rectal Resection

	Asthma/COPD Measure
Number of Episodes	233
Your TIN's Cost Measure Score	$6,549
National Average Cost Measure Score	$5,454
Your TIN's Cost Measure Score Percentile	76

THEY KEEP ADDING EPISODES….

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Cost Measure	Episode Group Type	Development Cycle
Elective Outpatient Percutaneous Coronary Intervention	Procedural	Wave 1 (2017-2018)
Intracranial Hemorrhage or Cerebral Infarction	Acute Inpatient Medical Condition	Wave 1 (2017-2018)
Knee Arthroplasty	Procedural	Wave 1 (2017-2018)
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural	Wave 1 (2017-2018)
Routine Cataract Removal with Intraocular Lens Implantation	Procedural	Wave 1 (2017-2018)
Screening/Surveillance Colonoscopy	Procedural	Wave 1 (2017-2018)
Simple Pneumonia with Hospitalization	Acute Inpatient Medical Condition	Wave 1 (2017-2018)
ST-Elevation Myocardial Infarction with Percutaneous Coronary Intervention	Acute Inpatient Medical Condition	Wave 1 (2017-2018)
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	Wave 2 (2018)
Elective Primary Hip Arthroplasty	Procedural	Wave 2 (2018)
Femoral or Inguinal Hernia Repair	Procedural	Wave 2 (2018)
Hemodialysis Access Creation	Procedural	Wave 2 (2018)
Inpatient Chronic Obstructive Pulmonary Disease Exacerbation	Acute Inpatient Medical Condition	Wave 2 (2018)
Lower Gastrointestinal Hemorrhage	Acute Inpatient Medical Condition	Wave 2 (2018)
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural	Wave 2 (2018)
Lumpectomy, Partial Mastectomy, Simple Mastectomy	Procedural	Wave 2 (2018)
Non-Emergent Coronary Artery Bypass Graft	Procedural	Wave 2 (2018)
Psychoses/Related Conditions	Acute Inpatient Medical Condition	Wave 2 (2018)
Renal or Ureteral Stone Surgical Treatment	Procedural	Wave 2 (2018)
Asthma/ Inpatient Chronic Obstructive Pulmonary Disease	Chronic Condition	Wave 3 (2019-2020)
Colon and Rectal Resection	Procedural	Wave 3 (2019-2020)
Diabetes	Chronic Condition	Wave 3 (2019-2020)
Melanoma Resection	Procedural	Wave 3 (2019-2020)
Sepsis	Acute Inpatient Medical Condition	Wave 3 (2019-2020)

In use for 2021

Field tested & available 9/20

NEW EPISODES…

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Table 1: Your Cost Measure Score Performance (Glossary: Table 8)

	Diabetes Measure
Number of Episodes	468
Your TIN's Cost Measure Score	$7,991
National Average Cost Measure Score	$7,110
Your TIN's Cost Measure Score Percentile	71

Table 4: Cost Measure Performance by Episode Sub-Group (Glossary: Table 9)

Episode Sub-Group	Your Episode Count	Share of Episodes		Mean Ratio of Winsorized Annualized Observed to Expected Cost	
		Your TIN	National Average	Your TIN	National Average
Diabetes	468	100.0%	100.0%	1.17	1.04
Type 1 Diabetes	6	1.3%	2.2%	1.60	1.03
Type 2 Diabetes	462	98.7%	97.8%	1.16	1.04

SO WHAT CAN YOU REALLY DO?

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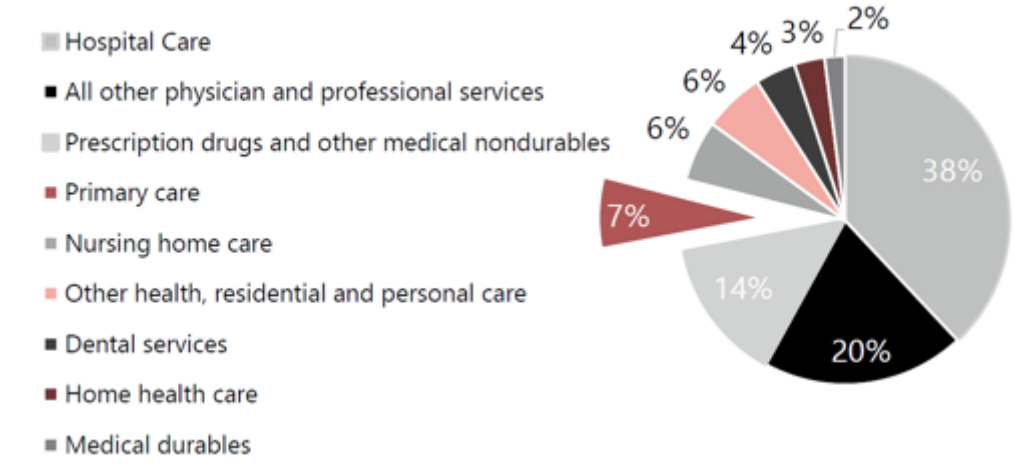
Know where your costs come from

Look at the WHOLE picture

WHERE DO PATIENT COSTS COME FROM?



IDENTIFY PATIENT COST OF CARE & SOURCE

Patient A

My billing for patient: $ 1,137

Total Cost of Care

Primary care (my office)	$ 1,137
Other professional care	$ 3,437
Outpatient	$25,533
Inpatient	$32,155
DME	$ 1,434
Medications	$ 2,412
TOTAL	$66,108

Patient B

My billing for patient: $ 4,038

Total Cost of Care

Primary care (my office)	$ 4,038
Other professional care	$ 3,415
Outpatient	$ 1,705
TOTAL	$ 9,158

Episodes are here to stay

9/19/20 CMMI noted it anticipates launching a mandatory episodic model following the conclusion of BPCI-A in 12/31/23

Attribution will always be a bit “messy”

Assessing clinical risk is …….**critical**

Difficult to pinpoint how to change cost scores

- Each cost measure has 10 points (20 in total for 2021)
- Detailed **cost reports from 2019** episodes: **available July 2021**

FINAL THOUGHTS ON COST

- Episodes are here to stay
- 9/19/20 CMMI noted it anticipates launching a mandatory episodic model following the conclusion of BPCI-A in 12/31/23
- Attribution will always be a bit “messy”
- Assessing clinical risk is …….**critical**
- Difficult to pinpoint how to change cost scores
  - Each cost measure has 10 points (20 in total for 2021)
  - Detailed **cost reports from 2019** episodes: **available July 2021**

WHERE IS MEDICARE HEADING?

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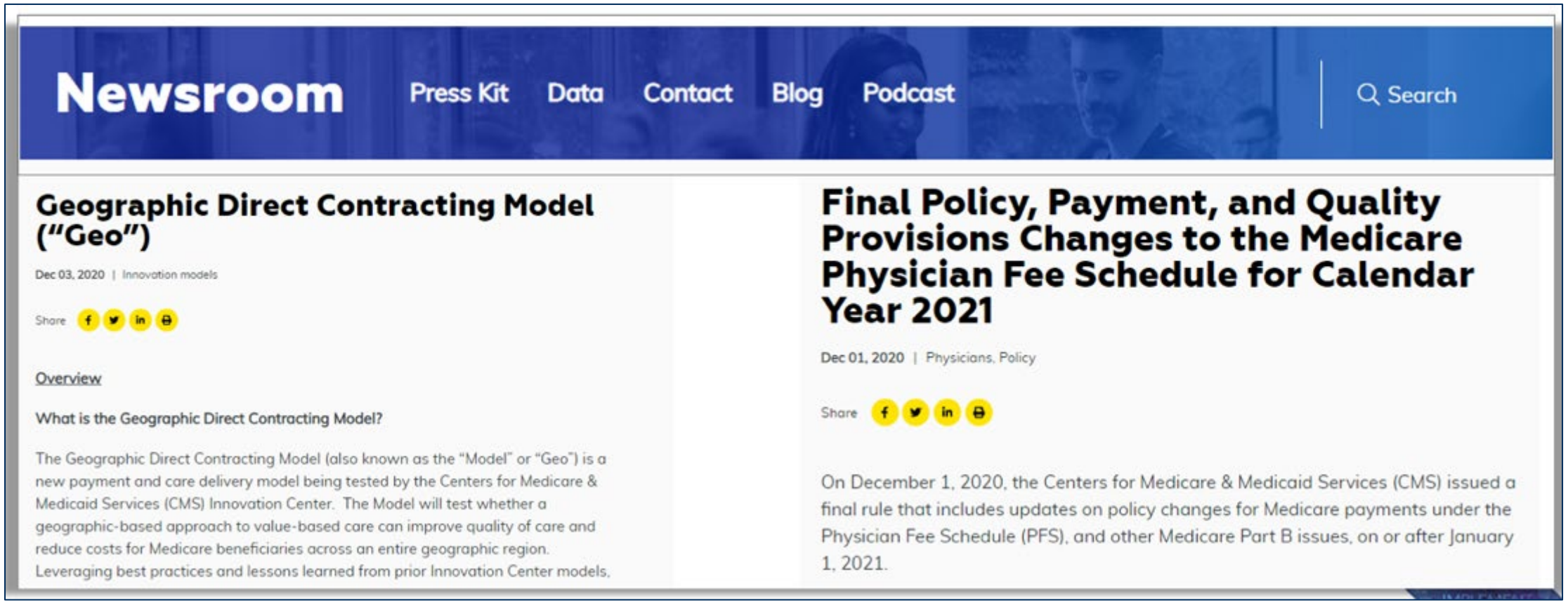

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Geographic Direct Contracting Model ("Geo")

Dec 03, 2020 | Innovation models

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Overview

What is the Geographic Direct Contracting Model?

The Geographic Direct Contracting Model (also known as the "Model" or "Geo") is a new payment and care delivery model being tested by the Centers for Medicare & Medicaid Services (CMS) Innovation Center. The Model will test whether a geographic-based approach to value-based care can improve quality of care and reduce costs for Medicare beneficiaries across an entire geographic region. Leveraging best practices and lessons learned from prior Innovation Center models,

Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021

Dec 01, 2020 | Physicians, Policy

Share

On December 1, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes updates on policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, on or after January 1, 2021.

MIPS VALUE PATHWAY (MVP): **DELAYED**

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Model Goals

SUBMITTING YOUR 2020 DATA

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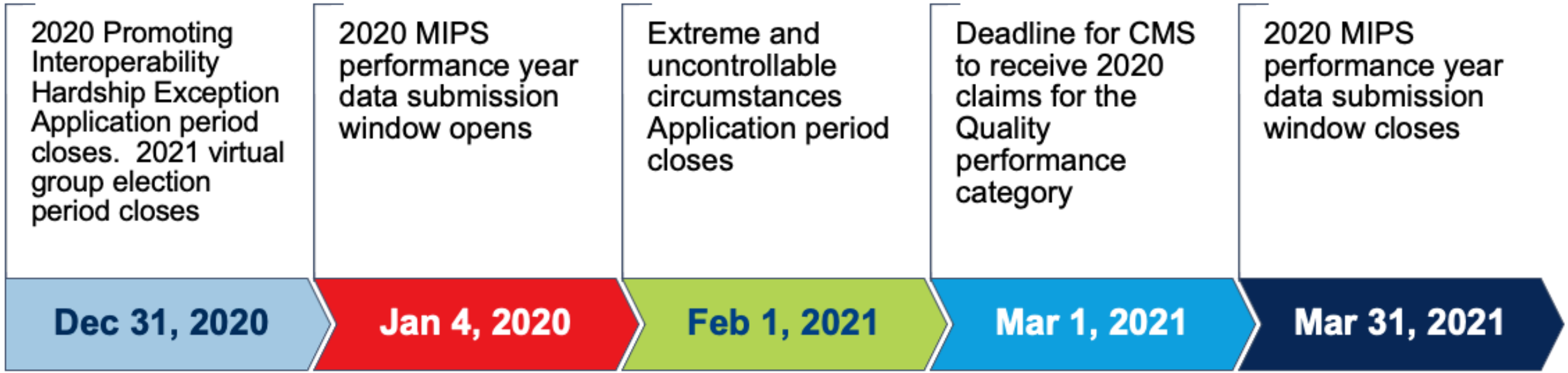
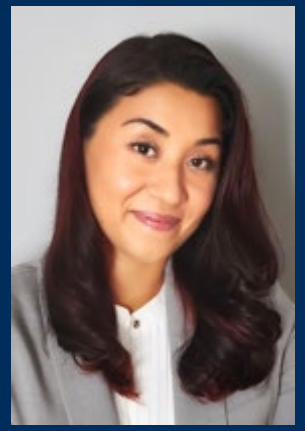


ATTRIBUTION METHODOLOGY

Understanding How Cost Measures Are Attributed to MIPS Eligible Clinicians



Claudia Vasquez
Associate Director, Medicare Payment & Quality Policy, ACC

COST PERFORMANCE CATEGORY MEASURES

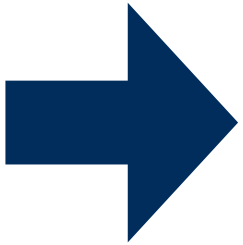
There are 21 total cost measures for the 2021 performance period.

- Total Per Capita Cost (TPCC)
- Medicare Spending Per Beneficiary Clinician (MSPB Clinician)
- 13 Procedural episode-based measures and 5 acute inpatient medical condition episode-based measures (18 measures total)

TPCC MEASURE ATTRIBUTION

Attribution is a combination of

1) E/M Primary Care Service
2) General Primary Care Service or 2nd E/M Service



- The “candidate event” triggers the start of a risk window that continues until one year after that date
- Multiple candidate events can occur within a performance year
- A patient’s costs are attributable to a clinician during months where the risk window and performance year overlap.

CANDIDATE EVENT

The TPCC attribution begins with a “candidate event,’ or services triggering the start of the primary care relationship.

Clinician bills an initial E/M primary care service

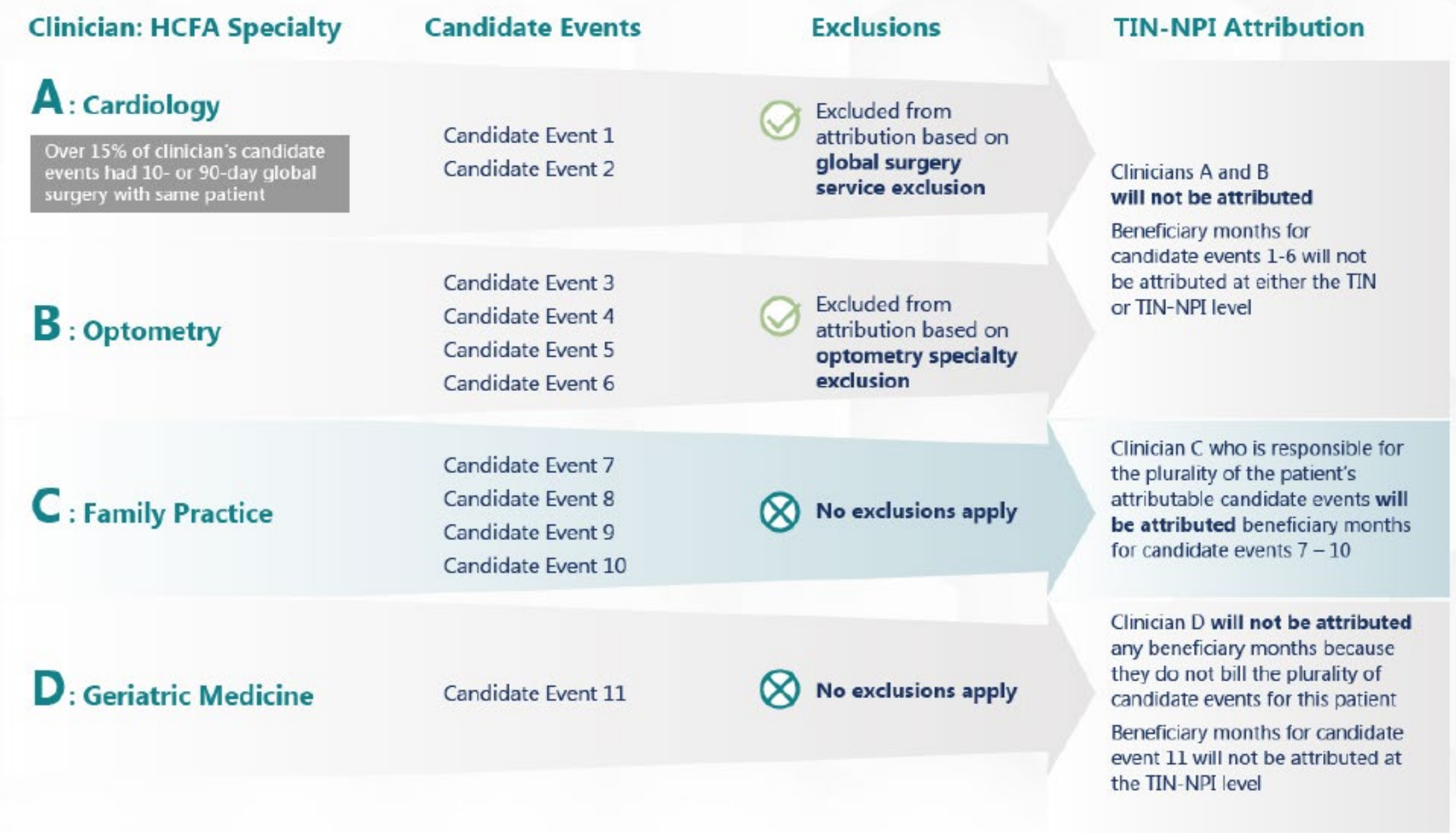
AND

Any clinician bills another primary care service **within 3 days**

OR

A clinician from the same TIN bills a second E&M primary care service or another primary care service **within 90 days.**

TIN-NPI Attribution When TIN Has 11 Candidate Events



MSPB CLINICIAN EPISODE ATTRIBUTION

MSPB Clinician attribution begins by identifying the “episode,” triggered by an inpatient hospital admission

CLASSIFYING EPISODES

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Episodes are classified as either medical or surgical, based on the Medicare Severity-Diagnosis Related Group (MS-DRG).

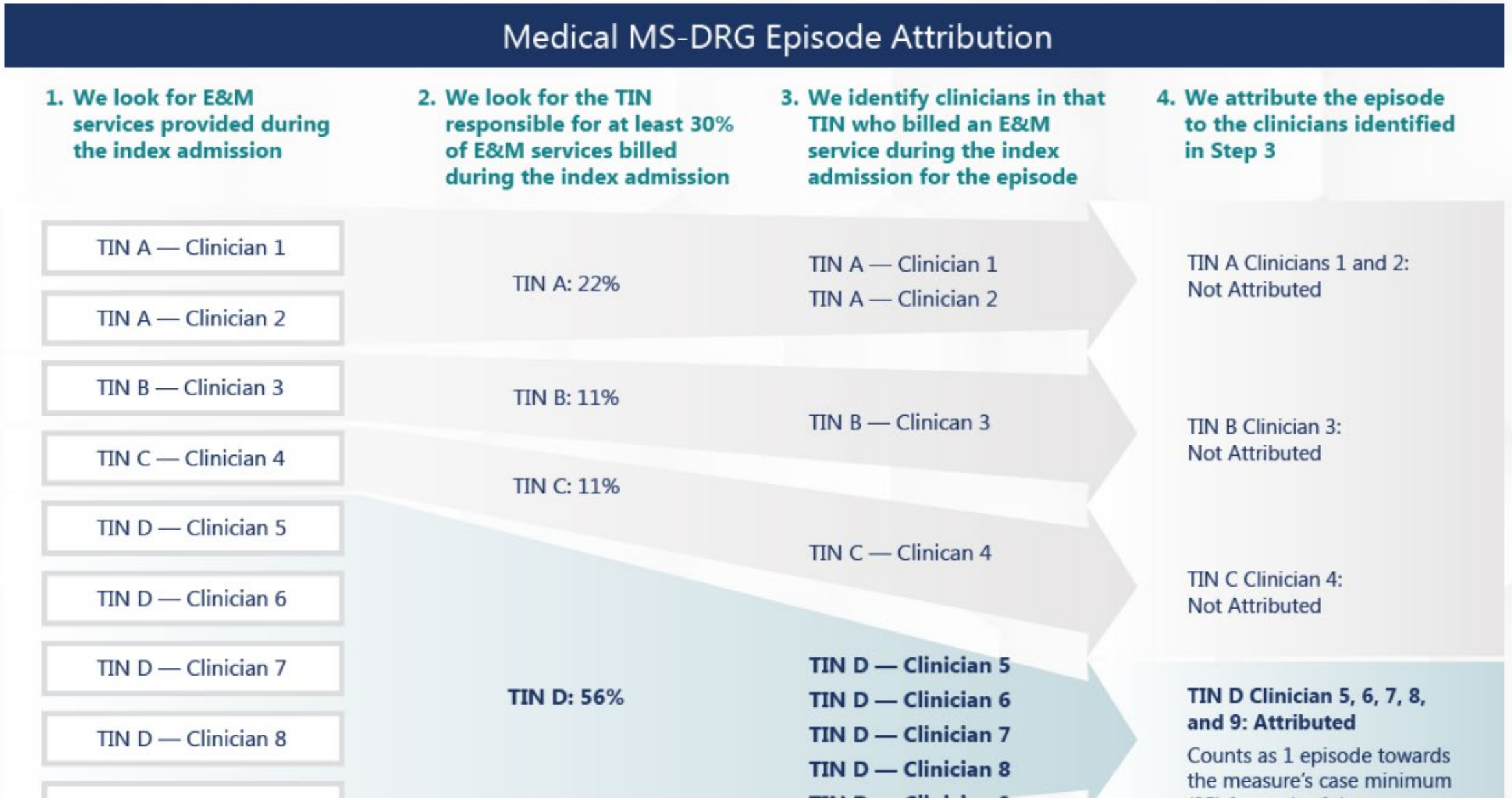
A **Medical Episode** Is:

- First attributed to the TIN billing at least 30% of the inpatient E/M services on Part B physician/supplier claims during the inpatient stay.
- Then attributed to any clinician in the TIN who billed at least one inpatient E/M service that was used to determine the episode's attribution to the TIN.

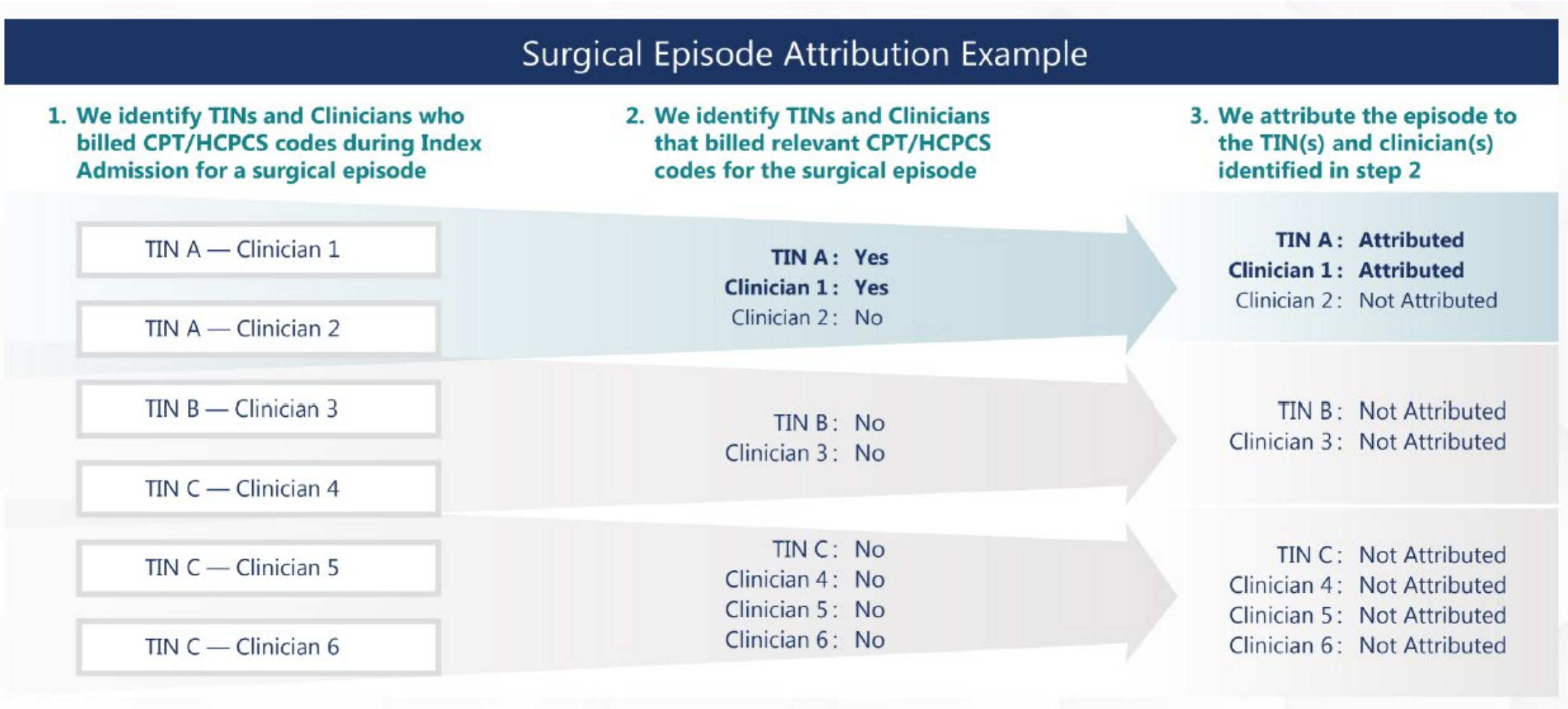
A **Surgical Episode** Is:

Attributed to the clinician(s) who performed any related surgical procedure during the inpatient stay as well as to the TIN under which the clinician(s) billed for the procedure.

Medical MS-DRG Episode Attribution



Surgical Episode Attribution Example



EPISODE-BASED MEASURE ATTRIBUTION

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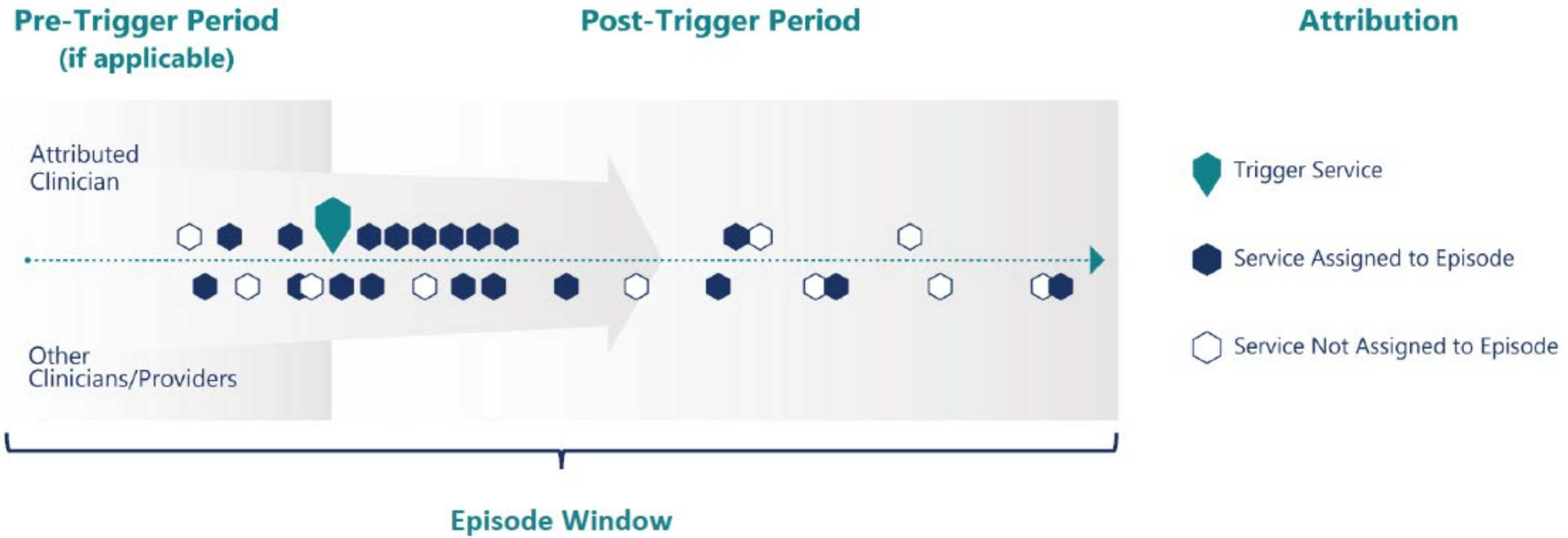
Acute Inpatient Episodes

- First attributed to the TIN billing at least 30%of inpatient E/M services on Part B physician/supplier claims during the inpatient stay.
- Then attributed to any clinician in that TIN who billed at least one inpatient E/M service during the inpatient stay.

Procedural Episodes

We attribute the episode to any clinician who bills the code that triggers the episode.

Episode-based Measure Attribution



TPCC MEASURE CALCULATION

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- Identify candidate events
- Apply service category and specialty exclusions
- Construct risk windows
- Attribute months to TINs and TIN-NPIs
- Calculate monthly standardized observed cost
- Risk-adjust monthly costs
- Apply specialty adjustment
- Calculate the measure score

MSPB CLINICIAN MEASURE CALCULATION

- Define the population of index admissions
- Attribute MSPB Clinician episodes
- Exclude unrelated services and calculate episode standardized observed cost
- Risk-adjust MSPB Clinician episode costs to calculate expected costs
- Exclude outliers and winsorize costs
- Calculate MSPB Clinician Measure score

EPISODE-BASED MEASURE CALCULATION

- Trigger and define an episode
- Attribute the episode to a clinician
- Assign costs to the episode and calculate the standardized episode observed cost.
- Exclude episodes
- Risk-adjust cost to calculate expected episode costs
- Calculate the measure score

Q&A

REGISTRATION *Open*

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SPRING'21

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General sessions on today's top of mind issues

Intimate breakout sessions on CV challenges

Pod sessions to share best practices with peers

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MedAxiom.com/CVTransforum

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REFERENCES

SELECTED REFERENCES

cms.gov/files/document/12120-pfs-final-rule.pdf

pecos.cms.hhs.gov

qpp.cms.gov/mips/how-eligibility-is-determined?py=2021

www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part

DIABETES

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Table 1: Your Cost Measure Score Performance (Glossary: Table 8)

	Diabetes Measure
Number of Episodes	468
Your TIN's Cost Measure Score	$7,991
National Average Cost Measure Score	$7,110
Your TIN's Cost Measure Score Percentile	71

Table 4: Cost Measure Performance by Episode Sub-Group (Glossary: Table 9)

Episode Sub-Group	Your Episode Count	Share of Episodes		Mean Ratio of Winsorized Annualized Observed to Expected Cost	
		Your TIN	National Average	Your TIN	National Average
Diabetes	468	100.0%	100.0%	1.17	1.04
Type 1 Diabetes	6	1.3%	2.2%	1.60	1.03
Type 2 Diabetes	462	98.7%	97.8%	1.16	1.04

DIABETES

Figure 1: National Distribution of Measure Scores

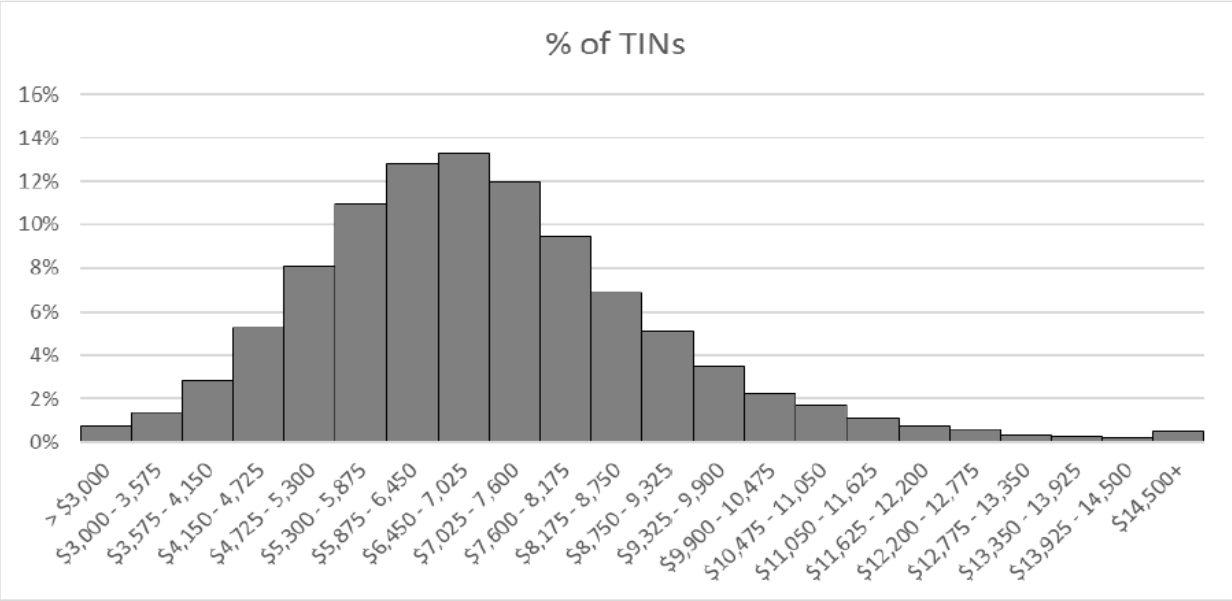

Table 3: Cost Distribution for Your Clinician Group's (TIN) Episodes and Episodes across All Clinician Groups

	Annualized Risk-Adjusted Cost					
	Mean	Cost Percentiles				
		5th (Least Expensive)	25th	50th (Median)	75th	95th (Most Expensive)
Your TIN's Episodes	$7,922	$793	$2,172	$4,316	$9,496	$24,321
Episodes across all Clinician Groups	$6,800	$594	$1,517	$3,379	$8,003	$23,457

DIABETES

Table 5: Cost and Use by Medicare Setting and Service Category (Glossary: Table 10)

Medicare Setting and Service Category	Average Annualized Cost of Services Per Episode (Conditional)			Share of Episodes with Certain Service		
	Your TIN	National Average	TINs in Your Risk Bracket	Your TIN	National Average	TINs in Your Risk Bracket
All Services	$9,177	$6,986	$9,565	100.0%	100.0%	100.0%
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding Emergency Department)	$2,383	$1,695	$2,263	100.0%	100.0%	100.0%
Outpatient Evaluation & Management Services	$1,370	$987	$1,267	100.0%	99.9%	99.9%
Major Procedures	$6,851	$7,217	$7,510	10.5%	11.4%	11.3%
Ambulatory/Minor Procedures	$1,571	$1,446	$1,492	18.4%	28.0%	30.2%
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	$301	$665	$688	2.6%	6.1%	5.8%
Ancillary Services	$522	$470	$614	99.6%	98.4%	98.4%
Laboratory, Pathology, and Other Tests	$136	$137	$160	99.4%	97.5%	97.4%
Imaging Services	$473	$389	$416	44.4%	43.5%	46.4%
Durable Medical Equipment and Supplies	$333	$422	$502	52.4%	50.7%	55.6%
Hospital Inpatient Services	$11,212	$10,212	$10,795	21.6%	23.9%	25.1%
Inpatient Hospital	$11,924	$11,903	$12,261	17.1%	19.2%	19.8%
Physician Services During Hospitalization	$1,767	$1,352	$1,476	21.6%	23.8%	24.9%
Emergency Room Services	$1,903	$1,298	$1,378	42.5%	40.5%	43.8%
Emergency Evaluation & Management Services	$1,832	$1,194	$1,272	42.5%	39.9%	43.1%
Procedures	$138	$259	$266	6.0%	15.3%	15.6%
Laboratory, Pathology, and Other Tests	$12	$13	$14	14.7%	20.9%	22.2%
Imaging Services	$65	$73	$73	31.6%	27.7%	29.6%
Post-Acute Services	$7,449	$8,300	$8,265	8.8%	18.6%	19.7%
Home Health	$4,348	$4,909	$5,203	6.2%	13.8%	15.0%
Skilled Nursing Facility	$7,744	$8,910	$9,279	4.1%	10.9%	9.9%
Inpatient Rehabilitation or Long-Term Care Hospital	$16,077	$21,440	$21,725	0.4%	4.1%	3.3%
Part D Services	$2,213	$2,370	$2,945	78.0%	75.3%	79.0%
All Other Services	$2,856	$2,588	$3,264	83.8%	79.3%	83.5%
Ambulance Services	$5,700	$1,752	$1,938	7.7%	8.8%	8.3%
Anesthesia Services	$111	$216	$227	5.1%	10.3%	9.3%
Chemotherapy and Other Part B-Covered Drugs	$4,534	$4,107	$4,490	4.5%	10.0%	10.2%
Dialysis	$308	$531	$515	2.1%	7.0%	5.5%
All Other Services Not Otherwise Classified	$115	$149	$170	10.5%	15.6%	17.1%

ASTHMA / COPD

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Table 1: Your Cost Measure Score Performance (Glossary: Table 8)

	Asthma/COPD Measure
Number of Episodes	232
Your TIN's Cost Measure Score	$6,271
National Average Cost Measure Score	$5,454
Your TIN's Cost Measure Score Percentile	73

Table 4: Cost Measure Performance by Episode Sub-Group (Glossary: Table 9)

Episode Sub-Group	Your Episode Count	Share of Episodes		Mean Ratio of Winsorized Annualized Observed to Expected Cost	
		Your TIN	National Average	Your TIN	National Average
Asthma/COPD	232	100.0%	100.0%	1.16	1.01
Asthma	17	7.3%	20.6%	0.98	0.96
COPD	190	81.9%	61.5%	1.13	1.02
Both Asthma and COPD	25	10.8%	17.9%	1.52	1.01

QUALITY PAYMENT PROGRAM

- CMS extended the Extreme and Uncontrollable Circumstances Hardship Exception due to COVID-19 through 2021, allowing eligible clinicians to apply to be held harmless from Merit-based Incentive Payment System (MIPS) or to have certain categories reweighted to zero if they experience disruptions related to the public health emergency.
- CMS postponed the **MIPS Value Pathways (MVP)** implementation for the 2022 performance period.
- CMS **increased the performance threshold** to avoid a penalty from 45 points in 2020 to 60 points in 2021. CMS maintained **the exceptional performance threshold** at 85 points for 2021.
- CMS finalized its proposal to lower the weight of the **Quality Category** performance score from 45 percent to 40 percent and to **increase the weight of the Cost Performance Category** from 15 to 20 percent of the MIPS final score.
- CMS estimates approximately 92.5 percent of eligible clinicians who submit MIPS data will receive a positive or neutral payment adjustment and between 196,000 and 252,000 eligible clinicians will be Qualifying APM Participants (QPs), will be excluded from MIPS, and will receive a five percent incentive payment in 2023.
- For performance year 2021, CMS finalized that Accountable Care Organizations (ACOs) participating in the **Medicare Shared Savings Program** is optional in 2021 and mandatory starting in 2022. ACOs will be required to report quality measure data for purposes of the Shared Savings Program via the APP, instead of the CMS Web Interface.

The 2021 hardship exception process is expected to mirror the 2020 process. Eligible clinicians and group practices will be able to submit a brief application listing "COVID-19" as the cause for requests to re-weight any or all MIPS performance categories. For instance, a physician can request a hardship on just the Cost Category and Quality Category and only be held accountable for Promoting Interoperability and Improvement Activity Categories. A physician can also request a hardship on all four categories to be held harmless from a MIPS penalty, if approved.

CMS finalized its proposal to allow APM Entities to apply to reweight MIPS performance categories as a result of extreme and uncontrollable circumstances, such as the public health emergency resulting from the COVID-19 pandemic. This policy will apply beginning with the 2020 performance period.

From the AMA

QPP FINAL RULE 2021

For the Improvement Activities performance category, we finalized policy to:

- Modify 2 existing improvement activities and remove 1 improvement activity that is obsolete.
- Continue the COVID-19 clinical data reporting improvement activity with modification as outlined in the September Interim Final Rule with Comment (IFC).
- Establish policies in relation to the Annual Call for Activities including an exception to the nomination period timeframe during a public health emergency (PHE) and an additional new criterion for nominating new improvement activities ("Include activities which can be linked to existing and related MIPS quality and cost measures, as applicable and feasible").
- Establish a process for agency-nominated improvement activities.

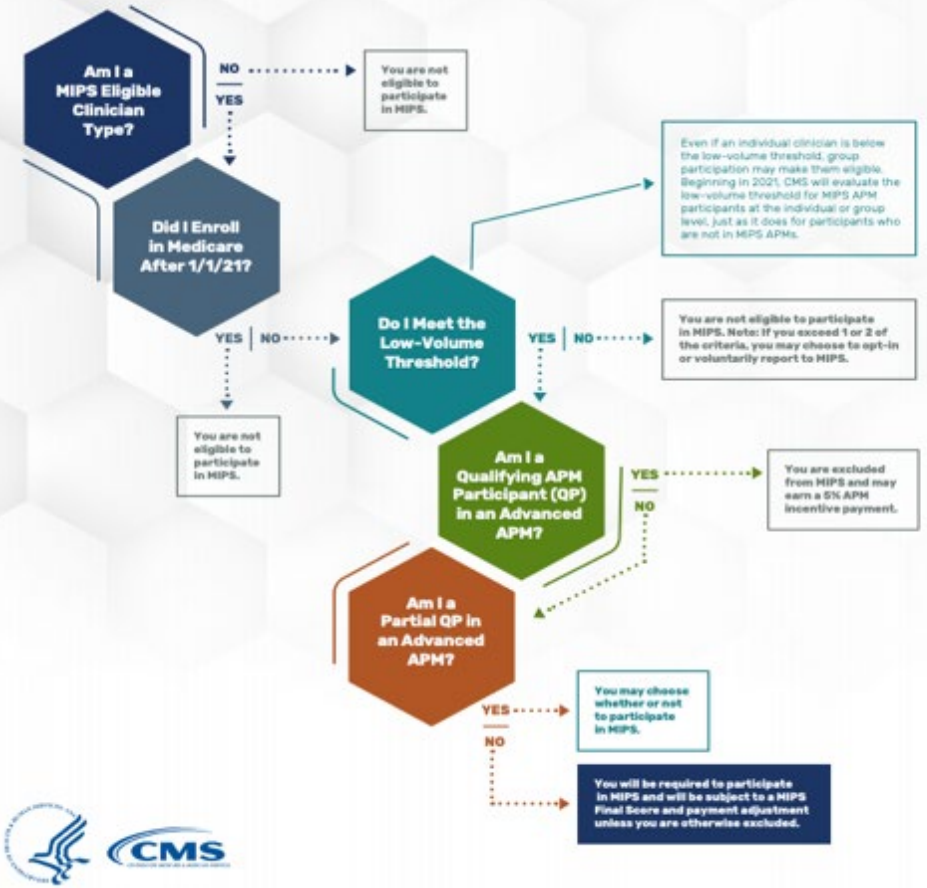
QPP FINAL RULE 2021

For the Promoting Interoperability performance category, we finalized policy to:

- Retain the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure and finalized to make it worth 10 bonus points.
- Change the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information by replacing “incorporating” with “reconciling.”
- Add an optional Health Information Exchange (HIE) bi-directional exchange measure as an alternative reporting option to the 2 existing measures for the HIE objective.
- Update certified electronic health record technology (CEHRT) requirements in response to the ONC 21st Century Cures Act Final Rule.

2021 MIPS Eligibility Decision Tree

Am I Eligible to Participate in the Merit-based Incentive Payment System (MIPS) in the 2021 Performance Year?



MIPS eligible clinician types:

Physicians (includes doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry; osteopathic practitioners; and chiropractors (with respect to certain specified treatment, a Doctor of Chiropractic legally authorized to practice by a State in which he/she performs this function)), Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, Clinical Psychologists, Physical Therapists, Occupational Therapists, Qualified Speech-Language Pathologists, Qualified Audiologists, Registered Dietitians or Nutrition Professionals, groups or virtual groups that include one or more of these MIPS eligible clinician types

Low-Volume Threshold Criteria for 2021:

- Bill more than $90,000 for Part B covered professional services under the Physician Fee Schedule; AND
- See more than 200 Part B patients; AND
- Provide more than 200 covered professional services to Part B patients

To achieve QP status in 2021, you must:

- Receive at least 75% of Medicare Part B payments; OR
- See at least 50% of Medicare patients through and Advanced APM Entity.
- Additionally, 75% of practices need to be using CEHRT within the Advanced APM Entity.

To achieve partial QP status in 2021, you must:

- Receive at least 50% of Medicare Part B payments; OR
- See at least 35% of Medicare patients through an Advanced APM Entity.

2021 Determination Periods and Snapshots

Merit-based Incentive Payment Systems (MIPS) Determination Period

For the Merit-based Incentive Payment System (MIPS), we review past and current Medicare Part B Claims and PECOS data for clinicians and practices twice for each Performance Year. Each review, or "segment", looks at a 12-month period. Data from the first segment is released as preliminary eligibility. Data from the second segment is reconciled with the first segment and released as the final eligibility determination.

Segment	Release on Quality Payment Program Site
Segment 1 Covers October 1, 2019 – September 30, 2020	**Initial Eligibility** December 2020
Segment 2 Covers October 1, 2020 – September 30, 2021	**Final Eligibility*** November 2021

2021 Quality Measures
Federal Register 2020
beginning pg. 1821

TABLE Group B: New Specialty Measures Sets and Modifications to Previously Finalized Specialty Measure Sets Finalized for the 2023 MIPS Payment Year and Future Years

We proposed to modify the previously finalized specialty measures sets below based upon review of updates made to existing quality measure specifications, proposed the addition of new measures for inclusion in MIPS, and considered the feedback provided by specialty societies. There may be instances where the quality measures within a specialty set remained static, but the individual measures had proposed substantive changes in Table Group D. In the first column, existing measures with substantive changes described in Table Group D are noted with an asterisk (*), core measures that align with Core Quality Measure Collaborative (CQMC) core measure set(s) are noted with the symbol (§), and high priority measures are noted with an exclamation point (!). In addition, the Indicator column includes a "high priority type" in parentheses after each high priority indicator (!) to represent fully the regulatory definition of high priority measures. In addition, electronic Clinical Quality Measures (eCQMs) that are National Quality Forum (NQF) endorsed are shown in Table B as follows: NQF # / eCQM NQF #.

NOTE:

- In the instance a title and/or measure description had a substantive change finalized in Table Group D, the revised title and/or measure description is reflected in the specialty measure sets located in Table Group B.
- Under Table Group B, we respond to comments that are related to new measures that were proposed for addition to measure sets, and measures that were proposed for removal. Any comments received on previously finalized measures are out of scope and not included in this final rule.
- Measures that were not finalized for removal in this final rule have been added back into the applicable previously finalized specialty set(s) under Table Group B and the reason for their retention is addressed under Table Group C.

The definition of high priority at § 414.1305 includes an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure.

The following specialty measure set was excluded from this group because we did not propose any changes to this specialty measure set: Anesthesiology. Therefore, we refer readers to the CY 2020 Quality Payment Program final rule for the previously finalized Anesthesiology specialty measure set (84 FR 63218 through 63219).

MIPS VALUE PATHWAY (MVP)

MVPs must be established through rulemaking, but CMS did not finalize MVP candidates for CY2021. MVPs will not be available for MIPS reporting until CY 2022 or later.

However, CMS released a guidance document providing instructions and template for MVPs to include

- Measures and activities from the Quality, Cost, and Improvement Activities performance categories
- Set of Promoting Interoperability measures and Hospital-Wide 30-Day All-Cause Unplanned Readmission (HWR) Measure

APM PERFORMANCE PATHWAY (APP)

The APP is complementary to the MVPs and will be available only to participants in MIPS APMs and will be required for Medicare Shared Savings Program quality determinations for ACOs. (End to the APM Scoring Standard)

APP participation will be effective 2021.

- The APP is comprised of a fixed set of measures for each performance category, just as MVPs will be.
- For the 2021 performance period only, participants in ACOs can report the 10 CMS Web Interface measures in place of the 3 eCQM/MIPS CQM/Medicare Part B claims measures in the APP.

Other Finalized Policies

2015 CEHRT requirements for performance periods in CY 2021 and 2022.

QCDR and Qualified Registries will conduct data validation audits with specific obligations, on an annual basis, beginning with the 2021 performance period.

Delayed QCDR measure testing and data collection requirement until the 2022 performance period. Measures must be fully tested at the clinician level in order to be considered for MVP inclusion.

Automatic reweighting policies related to NPs, PAs, CRNAs, PTs, and other clinician types.