Surviving and thriving in the time of MACRA: What you need to know now to optimize your future.

Risk Adjustment in the Resource Use Performance Measures

2017 SGIM Annual Meeting
Thursday, April 20, 2017

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Risk Adjustment in MACRA: Resource Use Performance Measures

Introduction to Hierarchical Condition Category (HCC) Coding

1. Risk Adjustment Methodologies
2. Medicare Advantage as risk adjustment paradigm

MACRA's Resource Based Measures in MIPS

1. Medical Spending Per Medicare Beneficiary (MSPB)
2. Per Capita Spending Per Beneficiary
3. Care Episodes and Clinical Condition Groups

Risk Adjustment Methodologies

Medicare

1. Medicare Advantage: Hierarchical Condition Categories
2. ACO's: Hierarchical Condition Categories

Health Insurance Exchanges: Hierarchical Condition Categories (modified)

Medicaid: at least 23 states use risk adjustment models

1.	Chronic Disability Payment System (CDPS)*	13
2.	Adjusted Clinical Groups (ACG)	4
3.	Diagnostic cost Groups (DxCG)	1
4.	Clinical Risk Groups (CRG)	1
5.	Episode Risk Groups (ERG)	1
6.	MedicaidRx	4

*or combined w MedicaidRx

Lieberman R, Key Features of Risk Adjustment Models, Mile High Analytics, 2015, http://www.iceforhealth.org/podcast/20160105_03_RADAR_3.pdf. Accessed 4-16-2017

Risk Adjustment in Medicare Advantage Plans

CMS adopted 100% risk adjusted MA payments in 2007

- Model based on health status and demographics
- Risk score reflects patient complexity and expected resource utilization
- ~9,000 HCC codes in 79 categories (out of `69,000 ICD 10 codes)
- Similar methodology used for ACO enrollees

Risk scores from base year determine payment in subsequent year

Risk Adjustment Factor (RAF) Score

- Includes demographic component driven by age and gender
- Medicaid enrollment, disability, select disease interactions contribute
- RAF score is the numerical sum of individual RAFs
- Average Medicare FFS patient has total RAF of 1.00

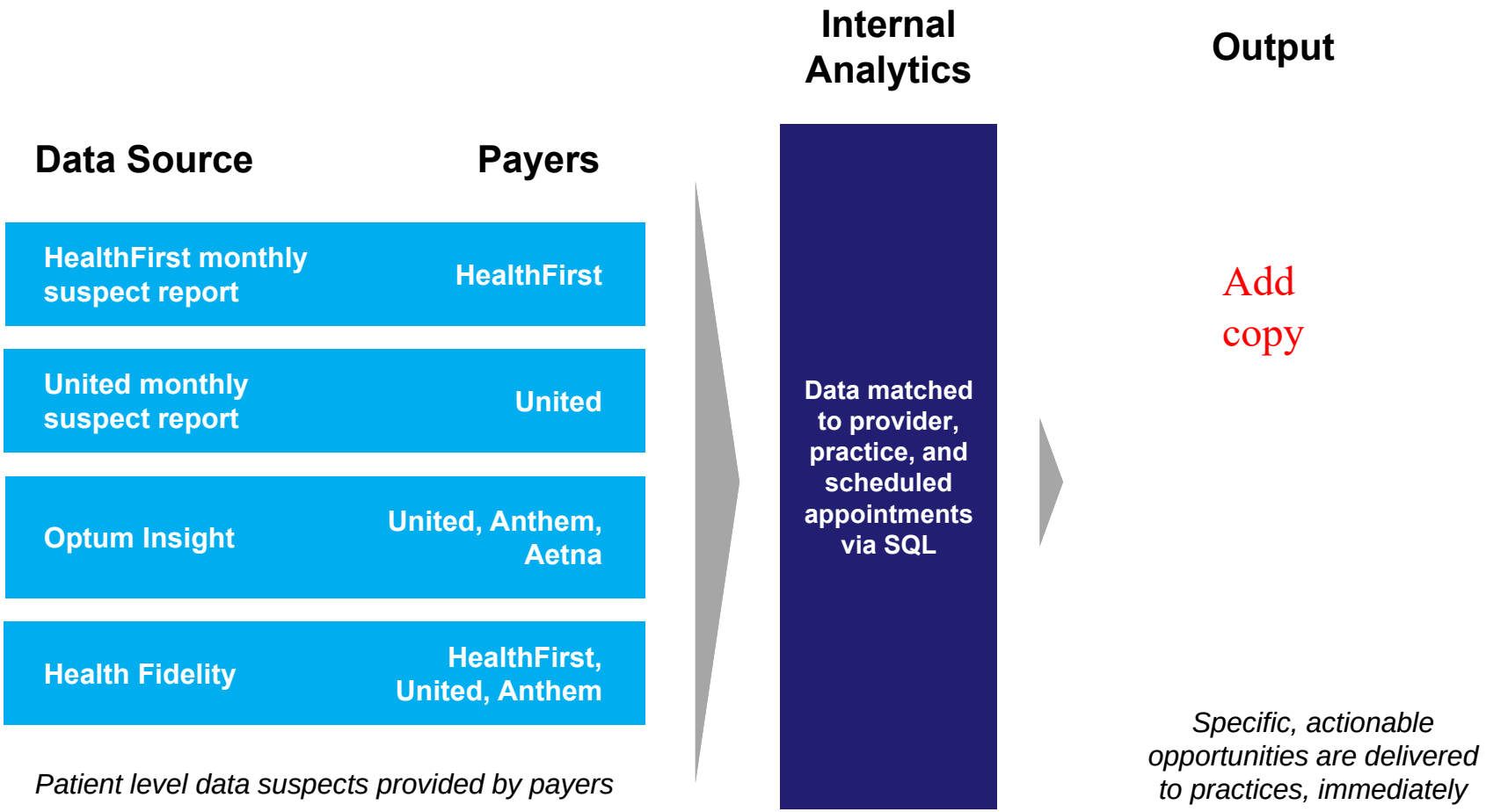
Risk Adjustment in Medicare Advantage Plans

NON-SPECIFIC CODING		SPECIFIC CODING	
ICD 10 Code	**RAF***	**ICD 10 Code**	**RAF***
Demographic RAF	**0.395**	Demographic RAF	**0.395**
E11.9: Type 2 diabetes mellitus without complications	0.104	E11.22: Type 2 diabetes mellitus with diabetic chronic kidney disease	0.318
N18.9 Chronic kidney disease, unspecified	0.000	N18.4: Chronic kidney disease, stage 4	0.237
E66.9: Obesity unspecified	0.000	E66.01: Morbid Obesity	0.273
F32.8: Other depressive epsiodes	0.000	F32.1: Major depressive illness, single episode, moderately severe	0.395
I25.9 Chronic ischemic heart disease, unspecified	0.000	I25.119: Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	0.140
Total	0.499	**Total**	1.758
***Payment Year 2017, Average Total RAF FFS Medicare is 1.000*			

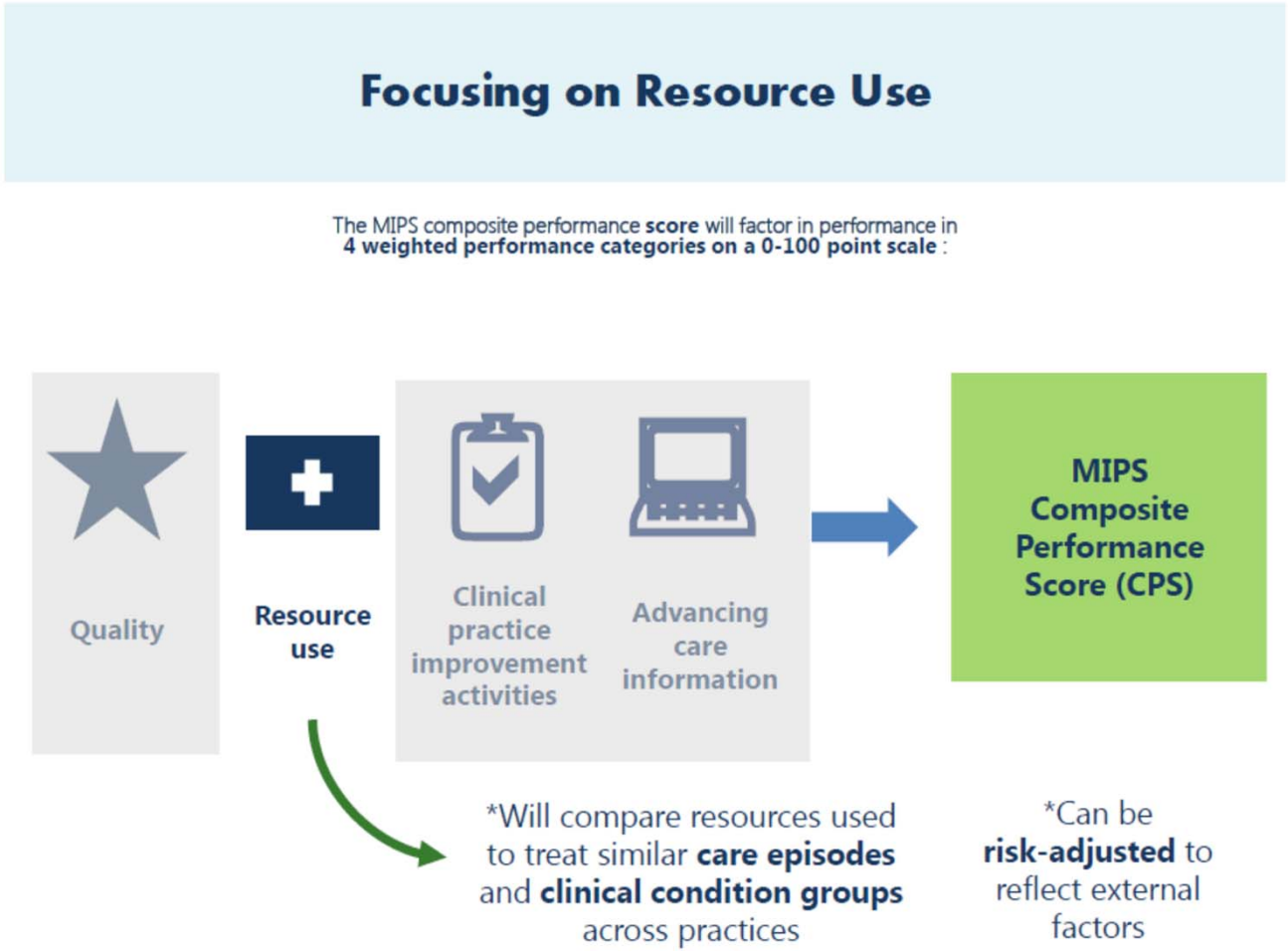
***Difference in RAF: 1.259

Carnavali F, Arron M, Risk Adjustment in Medicare Advantage Plans, SGIM Forum 2017:40(2)

Provider Groups Developing infrastructure to provide data to physicians at point of care



MIPS: Resource Use Performance Category



Merit-Based Incentive Payment System, Resource Use Performance Category, CMS, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Resource-Use-Performance-Category-slide-deck.pdf

MIPS Resource Use: Increasing CPS Weight Over Time

Performance Year	Payment Year	Weight
2017	2019	0%
2018	2020	10%
2019	2021	30%

MIPS Resource Use Category

Primary Performance Measures

1. Total Per Capita Costs for all Attributed Beneficiaries
2. Medicare Spending per Beneficiary (MSPB)
3. Episode Based Measures

Based on Physician Value-Based Modifier program and Quality and Resource Utilization Reports (QRUR), with modifications.

1. Use 2 of 6 measures (TCMB, MSPB)
2. Adds up to 41 episode based measures
3. Aligns primary care services with Medicare shared Savings Program
    a) Includes CCM and TCM codes
    b) Exclude nursing visits occurring in skilled nursing facility

Total Per Capita Costs for All Attributed Beneficiaries

Evaluates the overall efficiency of care delivered to beneficiaries by solo practitioners and physician groups

Payment standardized, annualized, risk adjusted measure,

1. Sum of Part A and B spending for each beneficiary attributed to TIN
2. Two step attribution process (includes TCM, CCM codes)

Risk adjustment methodology uses:

- Age, sex, disability status
- CMS HCC score in year preceding the performance year
- ESRD.

Specialty adjustment removed from measure

Minimal case volume: 20

Adapted from Measure Information Form, CMS https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-TPCC-MIF.pdf

Medicare Spending Per Beneficiary (MSPB)

Evaluates hospital efficiency compared to national median

Reflect costs on Part A and Part B claims incurred for hospitalizations:

1. 3 days prior to admission
2. Index admission
3. 30 days post-discharge
4. Attributed to TIN providing pleurality of care

Uses price standardization methodology,

Specialty adjustment removed

Adapted from MSPB, Measure Information form, CMS, accessed from CMS website 4/15/2017

Medicare Spending Per Beneficiary (MSPB)

Risk Adjustment includes:

1. Age, Disabled, ESRD, long term care
2. CMS HCC risk adjusted model from claims in 90 day period preceding hospitalization,
3. MS DRG

Proposed Minimum Episodes: 20

Adapted from MSPB, Measure Information form, CMS, accessed from CMS website 4/15/2017

Episode Based Measures

Goal: provide information to clinicians to reduce cost/promote high-value care.

Compares resources used to treat similar episodes and conditions across different providers and practices:

41 proposed episodes (10 procedural episodes proposed for 2017)

Costs: payments for Medicare beneficiaries related to episodes of care and treatment within defined time frames.

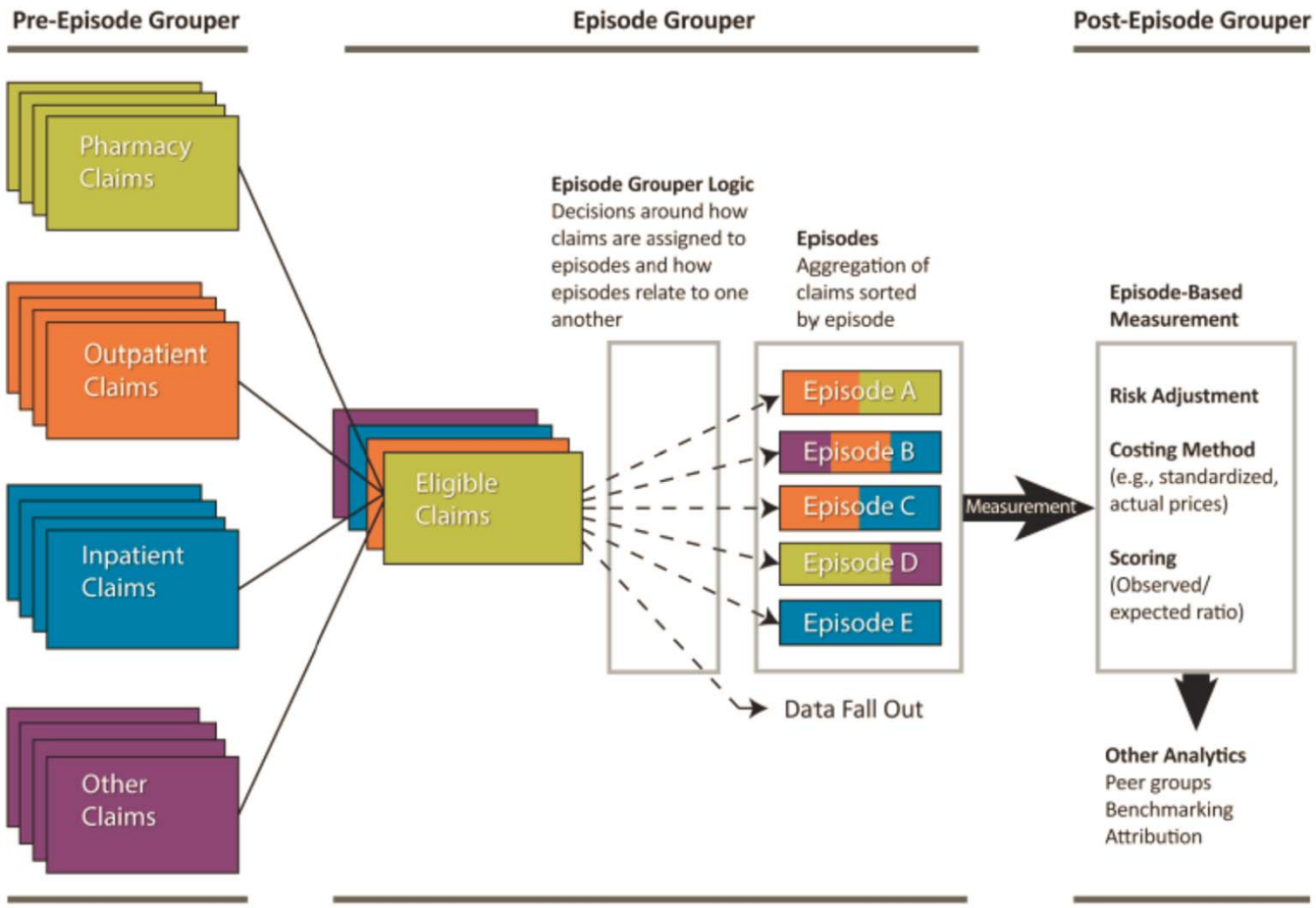
1. Includes Part A and B payments (not Part D)
2. Include cost of services related to diagnosis, treatment, post-acute care
3. In aggregate, targeting `50% of Medicare Part A & B spending

Proposed minimum cases: 20 per episode

Program being finalized: Public Comment on Episode Groups/Triggers ends 4/24/17

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

Episodes of Care: Grouping Episodes



Evaluating Episode Groupers: A Report from the National Quality Forum, National Quality Forum September 4, 2014

Episode Based Care: Risk Adjustment

Actual and expected costs after risk adjustment determined

Multiple statistical models using linear regression used to identify risk factors and adjust expected costs

Time periods:

1. Chronic conditions: updated quarterly
2. Acute Conditions and Treatment: risk adjusted based on factors known at opening of episode

Risk Factors:

1. Age, sex, recent enrollment (<6 month) in Medicare
2. Previously triggered condition episodes (co-morbidities)
3. Probability of death can be factored in, typically increasing costs

Resource Use Performance Category: Scoring

Performance Measure	Weight
Total Per Capita Costs for all Attributed Beneficiaries	10 points
Medicare Spending Per Beneficiary	10 points
Episode Based Measures	Up to 410 points

Resource Use Scoring Based on Decile Rank

Converting a Performance Rate to a Standard Score

Benchmark Decile	Hypothetical Resource Use	Scored
1	≥ $100,000	1.0 – 1.9
2	$75,893-$99,999	2.0 – 2.9
3	$69,003-$75,892	3.0 – 3.9
4	$56,009-$69,002	4.0 – 4.9
5	$50,300-$56,008	5.0 – 5.9
6	$34,544-$50,299	6.0 – 6.9
7	$27,900-$34,543	7.0 – 7.9
8	$21,656-$27,899	8.0 – 8.9
9	$15,001-$21,655	9.0 – 9.9
10	$1,000-$15,000	10

Performance	Score
$56,008 to $55,437	5.0
$55,436 to $54,866	5.1
$54,865 to $54,295	5.2
$54,294 to $53,724	5.3
$53,723 to $53,153	5.4
$53,152 to $52,582	5.5
$52,582 to $52,011	5.6
$52,010 to $51,440	5.7
$51,439 to $50,869	5.8
$50,868 to $56,008	5.9

Mingle D, 2017 Final Rule for MIPS/MACRA: Cost & Practice Improvement Performance Categories, Mingle Analytics, https://mingleanalytics.com/wp-content/uploads/2016/12/20161207_TheFinalRule2017_Quality_MingleAnalytics.pdf

APPENDIX

MIPS Eligible Clinicians

Eligible providers (inclusion of other providers starting in year 3)

1. Physicians (MD, DO, Dentists, Podiatrists, Optometrists, Podiatrists)
2. PA, NP
3. Clinical Nurse Specialists
4. CRNA
5. Non-patient facing clinicians:
    a) >75% of NPI Billing under group TIN non-patient facing
    b) Qualify if meet/exceed eligible criteria

Medicare Part B Clinician

1. >$30,000 per year
2. >100 cases

Except

1. Newly enrolled
2. Below threshold
3. Participate in APM

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MIPS Resource Use: Reporting options

Based on Medicare claims.

No submission requirements

Two Reporting Options

1. Individual: NPI TIN
2. Group
    a) 2 or more clinicians (NPIs) assigning billing rights to a single TIN
    b) Performance assessed as group across all MIPS categories

Merit Based Incentive Payment system: Resource Use Performance Category, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/QPP-MIPS-Quality-and-Cost-Slides.pdf

Per Capita Costs for All Attributed Beneficiaries

Two Step Attribution Process:

- Only members who received primary care are considered
- Step 1: Beneficiary receives most primary care services from PCP, NP, PA, CNS in that TIN compared with other TINs
- Step 2: If primary care services not received from providers in Step 1, then beneficiaries are assigned to the TIN of specialists providing the majority of these services

Measure Information form, CMS https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-TPCC-MIF.pdf

Total Per Capita Costs for All Attributed Beneficiaries

Primary Care Services Identified:

- Healthcare Common Procedure Coding System (HCPCS)/CPT codes:
  - 99201 – 99215
  - *99304 – 99340
  - 99341 – 99350
  - G0402 (Welcome to Medicare Visit)
  - G0438 & G0439 (Annual Wellness Visits)
  - 99495 & 99496 (Transitional Care Management)
  - 99490 (Chronic Care Management)

* Exclude services billed under CPT codes 99304-99318 when claim includes POS 31 modifier.

MIPS (Merit Based Incentive Payment Program: Resource Use/cost Performance Category, http://sticomputer.com/newwebsite/wp-content/uploads/2016/01/MIPSResourceUseCategory.pdf

Resource Use Category: Episodes of Care

Three Episodes Groups

1. Chronic condition episodes of care
2. Acute Inpatient Medical Condition Episode Groups
3. Procedural Episode Groups

Different attribution methodologies

Merit Based Incentive Payment system: Resource Use Performance Category, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/QPP-MIPS-Quality-and-Cost-Slides.pdf

Resource Use Performance Measures: Scoring

Scoring Example:
Dr. Joy Smith Submitted the following:

[A] RU	[B] Type of Measure	Number of Cases	Performance	[D] Measure Perf. Threshold	[E] Points Based on Decile	[H] Total Possible Points (10 points x [F])
M1	MSPB	20	15,000	13,000	4.0	10
M2	Total Per Capita	21	12,000	10,000	4.2	10
M3	Episode 1	22	15,000	18,000	5.8	10
M4	Episode 2	10	11,000	9,000	Below Case Threshold	N/A
M5	Episode 3	0	N/A	N/A	No Attributed Cases	N/A
M36	Episode 4	45	7,000	10,000	8.3	10
TOTAL					22.3	40

Resource use performance category score = (22.3/40) or 55.8%

27

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf

Episode Based Care: Constructing Unique Episodes

Opening:

1. Episode triggered by specific event (hospital stay, office visit, procedure)
2. Specific billing codes (trigger codes) indicate beneficiary experienced condition or treatment: ICD10, MS-DRG, CPT

Grouping:

1. Clinically relevant services are assigned to an episode using logic defining relatedness based on services/diagnosis codes on claim
2. Services may occur before, during and after trigger event

Closing:

1. Episodes closed after predefined time period (typically 90 days) after triggering event or patient disenrollment or death