MIPS and Million Hearts®

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Health Services Advisory Group (HSAG)
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MIPS = Merit-based Incentive Payment System
Objectives for Today

• Update: Million Hearts® Initiative
  – Collaboration with Health Resources and Services Administration (HRSA) through the Health Center Program
  – Cardiac rehabilitation
  – Million Hearts® and the QPP

• Health System Transformation: MACRA
  – The Quality Payment Program (QPP)
  – Options for participation in 2017
  – Opportunities for technical support

• Overview of current Centers for Medicare & Medicaid Services (CMS) Priorities
  – Shifting from volume to value-based payments
  – Program alignment and streamlining

MACRA = Medicare Access and CHIP Reauthorization Act of 2015
Million Hearts®

Goal: Prevent 1 million heart attacks and strokes by 2017

- National initiative co-led by the Centers for Disease Control and Prevention (CDC) and CMS
- To address the causes of **1.5M events** and **800K deaths** a year \( \rightarrow \$312.6\ B \) in annual healthcare costs and lost productivity and major disparities in outcomes
- In partnership with federal, state, and private organizations innovating and implementing programs for prevention and treatment
Key Components of Million Hearts®

Excelling in the ABCS
Optimizing individual care

- Prioritizing the ABCS
- Health tools and technology
- Innovations in care delivery

Keeping Us Healthy
Changing the context
Community

Health Disparities

ABCS = Aspirin; Blood pressure; Cholesterol; and Smoking cessation
Million Hearts® and the Health Center Program

HRSA-funded health centers address risk factors for cardiovascular disease. We do this as part of the HHS Million Hearts initiative to prevent 1 million heart attacks and strokes by the end of 2017.

Clinical Quality Measures

80,000 More Patients*
received aspirin therapy when appropriate in 2015 than in 2013

260,000 More Patients*
with hypertension achieved blood pressure control in 2015 than in 2013

800,000 More Patients*
were screened for tobacco use and provided needed cessation intervention in 2015 than in 2014
Uncontrolled Hypertension

Non-Hispanic black
(11.1 million)

- Controlled, 46.3%
  (5.1 million)
- Uncontrolled, 53.7%
  (6.0 million)

Non-Hispanic black: Uncontrolled
(6.0 million)

- Aware and Treated, 54.2%
  (3.2 million)
- Aware and Untreated, 18.7%
  (1.1 million)
- Unaware, 27.2%
  (1.6 million)

Source: NHANES 2013-2014
Physical Inactivity

Adults engaging in no leisure-time physical activity, NHIS 2015

- Overall: 30.0%
- Non-Hispanic white: 26.6%
- Non-Hispanic black: 38.4%
- Non-Hispanic Asian: 25.4%
- Hispanic: 38.6%

Source: NHIS 2015
Cardiac Rehabilitation (CR): What Is It?

• Comprehensive, team-delivered programs designed to:
   Limit the physiologic and psychological effects of cardiac illness
   Reduce the risk for sudden death and/or re-infarction
   Control cardiac symptoms
   Stabilize or reverse the atherosclerotic process
   Enhance the psychosocial and vocational status of selected patients

• Typically administered via 36 sessions over ~12 weeks

Source: Department of Health and Human Services (DHHS), Public Health Service (PHS), Agency for Health Care Policy and Research (AHCPR), National Heart, Lung, and Blood Institute (NHLBI). Clinical Guideline No. 17. 1995
CR: Who Benefits?

Strong evidence for people with a

– Heart attack, stable angina, heart failure (reduced EF)
– Coronary artery intervention; coronary bypass, heart valve, or heart, lung, and heart-lung transplant surgery

Source: Centers for Medicare & Medicaid Services
CR-Outcomes and Impact: What Is the Evidence?

• Reduces death from **all** causes by 11–24 percent and from cardiac causes by 26–31 percent
• Reduces hospitalizations by 31 percent
• Improves adherence to cardio-protective medication by 31 percent
• Enhances functional status, mood, and quality of life (QOL) scores
• **More is Better:** 36 versus fewer sessions reduces mortality (14–47 percent) and heart attacks (12–31 percent)

CR-Participation & Completion: The Current State

- Participation rates range 14–66 percent for heart attack, bypass, percutaneous coronary intervention (PCI), and only 10 percent for heart failure
- Lower rates among people of color, elderly, those with co-morbidities, or low socio-economic status
- Significant geographic variation: 7 to 54 percent by state

Source: Centers for Medicare & Medicaid Services
CR Infographic

CARDIAC REHABILITATION

SAVING LIVES ❤️ RESTORING HEALTH ❤️ PREVENTING DISEASE

BENEFITS OF CARDIAC REHABILITATION

Benefits to People

Those who attend 36 sessions have a 47% lower risk of death and 31% lower risk of heart attack than those who attend only one session.

Benefits to Health Systems

Costs per year of life saved range from $4,950 to $9,200 per person. Cardiac rehab participation also reduces hospital readmissions.

36 One Hour Sessions

Patient Counseling

Supervised Exercise

Nutritional/Lifestyle Education

HSAG HEALTH SERVICES ASSOCIATION GROUP
Approximately 450,000 FFS beneficiaries were eligible for cardiac rehabilitation (CR) in 2013

- 20 percent used CR at least once in 12 months
- 57 percent of CR users completed 25 or more sessions
Most Significant Barrier Identified in Literature: Referrals

• CR referrals are generally ≤30 percent of eligible patients

• Referral barriers include:
  – Lack of awareness of the benefits by referring MDs
  – No clear, consistent signal to patients and families
  – CR program is not integrated into cardiovascular services
  – No automated electronic referral process
    • “Opt-in” instead of “opt-out” hospital discharge orders

Source: Centers for Medicare & Medicaid Services
Patient-Level Barriers

• Logistics
  – Transportation/parking
  – Convenient hours
  – Proximity of programs

• Cost-share
• Competing responsibilities
• Cultural and language issues

Source: Centers for Medicare & Medicaid Services
Ades PA, et. al., Increasing Cardiac Rehabilitation Participation From 20 percent to 70 percent: A Road Map From the Million Hearts Cardiac Rehabilitation Collaborative, (2016) DOI.

https://millionhearts.hhs.gov/data-reports/reports.html
Participation and Completion

**Participation and Completion**

**Reaching the 36 Session Threshold is Challenging**

- Longer wait times following discharge reduce cardiac rehab enrollment.
- For every day a person waits to start cardiac rehab, they are 1% less likely to enroll in cardiac rehab.

**People who live outside of metropolitan areas are 30% less likely to participate in cardiac rehab programs.**

**Cardiac Rehab Participation Rates by Race (601,000 Medicare Patients)**

- 19.6% of eligible white patients participate
- 7.8% of eligible black patients participate

**We Know from Research How To Eliminate Barriers**

- The greatest predictor of participation is the strength of the physician's recommendation.
- Reduce the interval between hospital discharge and cardiac rehab program orientation by formalizing enrollment practices.
- Ensure access to services, through transportation options and extended hours.
- Where possible, reduce or eliminate financial burden on cardiac rehab participants.
- Support participation in cardiac rehab through community health workers, home health aides, and visiting nurses.
## Focus Areas

<table>
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<th>Incentives</th>
<th>Description</th>
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<td>Promote value-based payment systems</td>
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<td>Test new alternative payment models</td>
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<tr>
<td>Increase linkage of Medicaid, Medicare FFS, and other payments to value</td>
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<tr>
<td>Bring proven payment models to scale</td>
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<table>
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<tr>
<th>Care Delivery</th>
<th>Description</th>
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<td>Encourage the integration and coordination of services</td>
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<td>Improve population health</td>
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<td>Promote patient engagement through shared decision making</td>
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<tr>
<th>Information</th>
<th>Description</th>
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<td>Create transparency on cost and quality information</td>
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<td>Bring electronic health information to the point of care for meaningful use</td>
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Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
Chronic Disease Burden in the United States

Chronic Care Overview
• Half of all adult Americans have a chronic condition—117 million people.
• One in four Americans have 2+ chronic conditions.
• 7 of the top 10 causes of death in 2014 were from chronic diseases.
• People with chronic conditions account for 86 percent of national healthcare spending.
• Racial and ethnic minorities receive poorer care than whites on 40 percent of quality measures, including chronic care coordination and patient-centered care.

CMS and Chronic Care
• Medicare benefit payments totaled $597 billion in 2014
• Two-thirds of Medicare beneficiaries have 2+ chronic conditions
• 99% of Medicare spending is on patients with chronic conditions
• Annual per capita Medicare spending increases with beneficiaries’ number of chronic conditions

Sources: Centers for Medicare & Medicaid Services, Centers for Disease Control and Prevention (CDC), Kaiser Foundation, Agency for Healthcare Research and Quality (AHRQ)
What is Chronic Care Management (CCM)?

- CCM services by a physician or non-physician practitioner (physician assistant, nurse practitioner, clinical nurse specialist and/or certified nurse midwife) and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions expected to last at least 12 months (or until death), and that place the patient at significant risk of acute exacerbation/decompensation, functional decline, or death.

- Timed services – threshold amount of clinical staff time performing qualifying activities is required per month
- CCM is a critical component of care that contributes to better health and care for individuals
- CCM offers more centralized management of patient needs and extensive care coordination among practitioners and providers

Source: Centers for Medicare & Medicaid Services
What’s New for Calendar Year 2017

• Significant changes starting in 2017 based on feedback from stakeholders.

• Additional separate payment amount through three new billing codes
  - **G0506** (Add-On Code to CCM Initiating Visit, $64)
  - **CPT 99487** (Complex CCM, $94)
  - **CPT 99489** (Complex CCM Add-On, $47)
  - **CPT 99490** still effective for Non-Complex CCM ($43)

Visit the Connected Care Resource Hub at: [http://go.cms.gov/CCM](http://go.cms.gov/CCM)

For questions about the Connected Care campaign and its resources, contact [CCM@cms.hhs.gov](mailto:CCM@cms.hhs.gov)

For all CCM codes—Simplified and reduced billing and documentation rules, especially around patient consent and use of electronic technology

Source: Centers for Medicare & Medicaid Services
QPP Website

Quality Payment Program

Modernizing Medicare to provide better care and smarter spending for a healthier America.

https://qpp.cms.gov

Source: Centers for Medicare & Medicaid Services
The Quality Payment Program policy will reform Medicare Part B payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system.

Source: The Centers for Medicare & Medicaid Services
Part I: MIPS Basics
What Do I Need to Know?
What Is MIPS?

Performance Categories:

- Reporting standards align with APMs when possible.
- Many measures align with those being used by private insurers.

Clinicians will be **reimbursed under Medicare Part B based on this Performance Score.**

Source: The Centers for Medicare & Medicaid Services
What Are the Performance Category Weights?

Weights assigned to each category based on a 1 to 100 point scale

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
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<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Transition Year Weights**

*Note:* These are default weights; the weights can be adjusted in certain circumstances.

Source: The Centers for Medicare & Medicaid Services
MIPS Eligibility

What Do I Need to Know?
Eligible Clinicians

Clinicians billing more than $30,000 a year in Medicare Part B allowed charges AND providing care for more than 100 Medicare patients a year.

These clinicians include:

- Physicians*
- Physician Assistants
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetists

* Including medical doctor (MD), doctor of osteopathy (DO), doctor dental surgery (DDS), doctor of dental medicine (DMD), doctor of optometry (OD), doctor of occupational therapy (OT), physical therapist (PT), registered dietician (RD), clinical social worker (CSW)

Source: The Centers for Medicare & Medicaid Services
Who Is Exempt From MIPS?

**Clinicians who are:**

- Newly-enrolled in Medicare
  - Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

- Below the low-volume threshold
  - Medicare Part B allowed charges less than or equal to $30,000 a year
  - OR
  - See 100 or fewer Medicare Part B patients a year

- Significantly participating in Advanced APMs
  - Receive 25% of Medicare payments
  - OR
  - See 20% of Medicare patients through an Advanced APM

Source: The Centers for Medicare & Medicaid Services
MIPS Participation
What Do I Need to Know?
When Does MIPS Officially Begin?

Performance year

• Performance period opens January 1, 2017.
• Performance period closes December 31, 2017.
• Clinicians care for patients and record data during the year.

March 31, 2018 Data Submission

• Deadline for submitting data is March 31, 2018.
• Clinicians are encouraged to submit data early.

Feedback available

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

Adjustment

• MIPS payment adjustments are prospectively applied to each claim beginning on January 1, 2019.

Source: The Centers for Medicare & Medicaid Services
Pick Your Pace for Participation for the Transition Year

- Some practices may choose to participate in an Advanced APM in 2017

Submit Something:
- Submit some data after January 1, 2017
- Neutral payment adjustment

Submit a Partial Year:
- Report for 90-day period after January 1, 2017
- Neutral or positive payment adjustment

Submit a Full Year:
- Fully participate starting January 1, 2017
- Positive payment adjustment

MIPS

Participate in an Advanced APM

Not participating in the QPP for the Transition Year will result in a negative 4 percent payment adjustment.

Note: Clinicians do not need to tell CMS which option they intend to pursue.
MIPS: Choosing to Test for 2017

- Submit a **minimum** of 2017 data to Medicare
- **Avoid** a downward adjustment
- Gain familiarity with the program

Submit Something

Minimum Amount of Data

1 Quality Measure

OR

1 Improvement Activity

OR

4 or 5* Required ACI Measures

* Depending on certified electronic health record technology (CEHRT) edition

Source: The Centers for Medicare & Medicaid Services
Million Hearts Quality Measures for MIPS

• **A:** Ischemic Vascular Disease (IVD): Use of **Aspirin** or Another **Antiplatelet**.

• **B:** Hypertension: Controlling High **Blood** Pressure (140/90 mmHg)

• **C:** **Cholesterol:** Fasting Low Density Lipoprotein (LDL-C Test Performed AND Risk-Stratified Fasting LDL-C with statin administration

• **S:** Smoking/Tobacco Use: Screening and Cessation Intervention
Million Hearts Improvement Activities for MIPS

- **Activity ID**
  IA_PM_8

- **Subcategory Name**
  Population Management (participate in MH)

- **Activity Weighting**
  Medium
MIPS Reporting
What Do I Need to Know?
### Submission Methods

#### Quality

<table>
<thead>
<tr>
<th>Individual</th>
<th>Group</th>
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</table>
| • Qualified Clinical Data Registry (QCDR)  
• Qualified Registry  
• EHR  
• Claims | • QCDR  
• Qualified Registry  
• EHR  
• Administrative Claims  
• CMS Web Interface  
• CAHPS for MIPS Survey |

*Must be reported via a CMS approved survey vendor together with another submission method for all other Quality measures.*

#### Improvement Activities

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| • QCDR  
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• Attestation | • QCDR  
• Qualified Registry  
• EHR  
• CMS Web Interface  
• Attestation |

#### Advancing Care Information

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• Qualified Registry  
• EHR  
• Attestation  
• CMS Web Interface |

Source: The Centers for Medicare & Medicaid Services
Technical Support Available to Clinicians

• Integrated Technical Assistance Program
  – Full-service, expert help
    • Quality Payment Program Service Center
    • Quality Innovation Network–Quality Improvement Organizations
    • Quality Payment Program—Small, Underserved, and Rural Support
    • Transforming Clinical Practice Initiative
    • APM Learning Networks
  – Self-service
    • QPP Online Portal

All support is FREE to clinicians

https://qpp.cms.gov/education

Source: The Centers for Medicare & Medicaid Services
Additional Resources

Quality Payment Program:  
gpp.cms.gov  
1-866-288-8292  
TTY: 1-877-715-6222  
QPP@cms.hhs.gov

APM Learning Model Support List:  
http://innovation.cms.gov

Transforming Clinical Practice Initiative (TCPI):  
PTN Map: https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices  
To enroll in TCPI, contact:  
TCPI.ISC@Truvenhealth.com

Quality Improvement Organizations:  
QIN-QIO Map: http://qioprogram.org/

Source: The Centers for Medicare & Medicaid Services
Request No-Cost Assistance from HSAG

www.hsag.com/QPP

Call Us 844.472.4227

Email Us HSAGQPPSupport@hsag.com
Thank you!

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