Making “Cents” of the Quality Payment Program Cost Category
Transcript from Live Session

Tuesday, May 22, 2018

Laurie Fink: Good afternoon everyone and welcome to today's webinar, Making 'Cents' of the Quality Payment Program Cost Category. My name is Laurie Fink and I'm a Communication Specialist with Quality Insights. I'll be serving as the host for today's session. We will get things started in just a moment, but first I'd like to review a few housekeeping items.

All participants enter today's webinar in a listen only mode. Should you have a question during today's presentation we ask that you please type it into either the chat or the Q and A box to the right of your screen and we will answer as many questions as we can at the end of the program. Today's webinar is being recorded. The recording will be posted on the Quality Insights website as well as the Quality Insights QPP support center website later this week. It can be found on the archived events page. You should have received a copy of the slide deck for today's webinar earlier today via email, but if for some reason you did not I will send everyone a link to where these resources are posted as soon as they are available.

It is now my pleasure to introduce you to today's speakers, Roxanne Fletcher and Julie Williams. Both Roxanne and Julie are Practice Transformation Specialists with Quality Insights and are helping providers within our network achieve success within the quality payment program. Kicking things off today will be Roxanne. Rox, over to you.

Roxanne: Good afternoon everybody and we're so delighted that you could join us today for making 'cents' of the quality payment cost category. I also wanted to do a shout out to Lisa Sherman. She assisted Julie and myself in putting the presentation together. Let's get started.

The objectives of the webinar today are reminder to check your 2018 eligibility. Learn why measuring cost is important for MIPS. Learn the benefits of documenting your patients medical conditions, risk adjustment, coding. Understand the value of the ... Next slide.

Eligibility status. The first step for 2018 is to check your eligibility status. To do that you can use the link on the screen. This link will also explain the 2018 eligibility guidelines. If you're an individual or group who billed less than $90,000 or see less than 200 Medicare patients you are exempt. If you exempt as an individual you may be able to be included in a practice group. If there is more than one provider at your practice you may want to consider submission as a group so you can earn incentive increased reimbursement for Medicare claims. Next.

You can also check on your group status. If you do have an EIDM account you can log into now and you can see they're two ways to check in for your eligibility. I want to make a special note that I've heard from practices that they go in and check the group and provider may be nothing, you want to make sure that if you've added a new provider to your practice to go into PECOS and update the information so it reflects that, that provider is a member of your practice. There's also here a link for a YouTube video that CMS has produced that will step you through how to check your group eligibility. Reminder, if you don't already have an EIDM account we encourage you to sign up as soon as possible. This site is where you can access valuable information such as the 2018 MIPS report and other data about your practice. Next.

Why are we focusing on cost? Measuring cost is an important part of MIPS because it shows the resources clinicians use to care for patients. Those resources are for instance hospitals, skilled nursing facilities and hospice stays. It could be outpatient services including PT and OT. Home health services, office visits with specialists as well as durable medical supply. These all count in your Medicare reimbursement and payments. Medicare payments are made under the Physician Fee Schedule, Medicare Part B services given to patients during an episode of care. I will get into this a little bit deeper later. This is for finding items and services from claims given in a specific timeframe. Next please.

The cost category replaces value based modifier. It replaces the value-based program as of 2016 was the last performance year for the value-based modifier. 2017 is the last payments adjustments will be applied for that. The program included physicians, physician assistants, nurse practitioners, all those that are also eligible and ID'ed in the MIPS program. Next please.

QRURs, which are the Quality and Resources Use Reports, were provided for this value-based modifier and the PQRS, the physician quality reporting system to give you feedback. I know some of you have used those reports and have learned a lot from them and for this year, for 2017, they have developed a new report called the MIPS feedback report. Some of it will be familiar to you. It'll be similar to what was in the QRUR report. They will be available this summer for you to access through your EIDM account. Next please.

Cost measures in 2018. What are they? They will use two cost measures to measure performance in 2018 - the total per capita cost measure, also known as TPCC, and the Medicare per beneficiary measure, known as MSPB. The per

capita measures all Medicare A and B costs during the MIPS performance period. The Medicare spending measures what services Medicare pays for that were performed by an individual clinician during the period immediately before, during and after a patient's hospital stay. This was an MSPB episode. Right now, I have the, this will go back to the next ... I'm sorry. Go forward one slide for me.

The total per capita cost.... Okay, I'm sorry. This is where my lovely associate Julie will take over. Julie is going to into much more detail, what is involved in the cost category and get your pen and pencils ready to take some great notes as Julie provides you in depth details.

Julie Williams: Why thank you, Roxanne. Thanks everybody for joining us today. Again, I just want to remind everybody to put your questions in the chat box. Now, Roxanne has explained what cost is, now let's see if we can make some sense out of it. The TPCC evaluates the overall cost of the care provided to beneficiaries attributed to clinicians. This includes all part A and B costs during the performance period. This includes inpatient, outpatient, skilled nursing facilities, home health, hospice, durable medical equipment, prosthetics, orthotics, and supplies. Now, lucky for us part D covered prescription drug costs are not included. Next.

For the TPCC measures, the beneficiaries are assigned to a single Medicare tax identification number or NPI number. This slide comes directly from the CMS fact sheet on measure information. I want to make sure that you're aware that the level of primary care services they receive is one of the two step processes that they consider. The other is the clinician specialties that perform these services. Next.

Only beneficiaries who receive primary care services during the performance period are assigned to the tax identification number or the NPI. Now, the primary services included are the evaluation and management services given in an office and other non-inpatient and non-emergency room setting, initial Medicare visits, and annual wellness visits. If you're a specialist caring for a patient make sure your patients seeing their Medicare Primary Care clinician. This is really important because we want to make sure those people fall off of your list after you've seen them for the episode of care. When you're a primary care clinician offering an annual wellness exam is a great way to manage their cost. We'll be providing an annual wellness visit toolkit at the end of our slide. Next.

Here's another example of the episode care that Medicare is going to use. Now, if you pay close attention you're going to be attributed three days before admission and 30 days post. The items and services provided to the patient during this care will be charged to your cost. Now, Medicare developed these and informed clinicians on the cost of care for an episode of treatment. That's kind of a rough way for them to actually give us some information there. Next slide please.

I want to review the cost category again. Now, it's worth 10% of the total MIPS score in 2018. The performance period is one full calendar year. It's not what you charge for your service. There's no extra reporting required for this category. CMS will calculate your score based on administrative claims. Again, those part A and B claims. Now, pay close attention to this, if only one measure can be scored it will serve as the performance category score. If a measure cannot be scored due to not meeting the threshold, then the cost category will be re-weighted to the quality category. Now performance is compared against other MIPS eligible clinicians and groups during the same reporting period. It's not like previous where you were compared to your benchmarks from your previous year. Next slide.

Now let's dig a little bit deeper. It's important to let Medicare know the health of your patient. How healthy or how sick are your patients? It's crucial for that primary care provider to be aware of when and where their patients access care. Again, this is done efficiently with an annual wellness exam. We want to make sure that they're not just receiving care from you. They're not going just to the ER. They're not going to after-hours care and you're getting attributed to all this cost. You're kind of the gatekeeper in making sure that you're able to provide care when they need it is important. If you're a specialist it's absolutely critical to ask every Medicare patient when they last saw their primary care provider.

Again, you ask why? Well, if you were attributed to that patient you're going to be attributed to them for a full year. Now if they don't go back and see their primary care or another provider they're going to stay on your attributed patient list. Well, if you're only going to see them from one episode of care that's going to be kind of pretty costly for you to continue to treat this patient and get their care charged to you. Next.

Now this is another interesting fact. Did you realize that every January one your patients start out with a clean slate, every chronic and non-resolved diagnosis fell off? You literally have to code at least once per calendar year all their chronic and non-resolved diagnoses. If you don't it's called falling off. Now, can you imagine being a paraplegic of 20 years or more and every January you're healed, your healthy under your doctor codes that again. Now, that for me would cause problems with ordering equipment or different things down the road. It's kind of really important that you make sure that you want to get everything coded importantly and this you start by building a risk for your patients. Next slide.

With your coding your patients health is the basis of building your risk score and making sure you have all those unresolved conditions reported. The sicker your patient, the higher the risk score, and consequently, the higher your payment will be from Medicare. Next slide.

Now as you're building your risk assessment the goal is getting a good risk adjustment. It's making sure you're accurately comparing yourself to your peers

and you're doing a better job in letting Medicare know the health of your patient. You're doing this by removing the differences in health and removing other risk factors that impact outcomes that are not under your TINs control. You do all of this with your coding. Next slide please.

This is your HCC coding. Now, risk adjustment is based on everything that you code. That's the major thing here. Codes are adjusted to account for the different patient characteristics like multiple chronic conditions. The sicker the patient, the higher the risk score. When you're doing this you might want to think about customizing your EHR to help you code more efficiently or making sure that you actually maybe have a coding cheat sheet, something that you can reference and look at on the fly there, so it's not something that you're always struggling with. Next slide please.

As you are coding you are building this risk score I want you to remember your chronic disease burden. When you are coding those with your ICD-10 codes think complete, accurate, and consistent. Think of the severity, the complexity, and the completeness. Building a correct, positive risk score for your patient. Now, I'll turn it back over to Roxanne. Next slide and thank you.

Roxanne: Hopefully you've taken some great notes. Prior to 2017, cost measure feedback was available on the quality and resource use report from the VBM program. Don't you just love all these (acronyms), value-based modifier? In July 2018, CMS will provide cost measure feedback based on the 2017 MIPS performance year with a new report called the MIPS feedback report, which I mentioned earlier. This report will replace the old QRUR. Next slide.

Although the cost performance category doesn't expect your payments for the transition year, CMS will provide performance feedback for the purpose to help you get familiar with cost measure. This information and resource is from the cost fact sheet, which we have noted later one in our slides. This feedback will help providers going forward understand the cost category. Even though the QRUR will no longer be distributed because it was part of another program and in 2016 you can still review your report if you haven't done so already just to get familiar an understanding of how it works. To review, this will give your Medicare spending per beneficiary and total per capita cost. Both the QRUR and the feedback reports can be accessed via your EIDM account and also on our research page we have a link that you can take that will show you how to set up an EIDM account if you don't already have one. We are also here to help you, assist you, with understanding these reports. Next slide.

Improving the category score. Does your practice have control how patients spend their Medicare dollars? What have we heard time and time again from many of our practices when we've had conversations is that they feel they have no control of cost. We understand that some things may be out of your reach, but you can make a difference. There are ways you can monitor and help reduce cost that negatively effects your practice.

For instance, properly coding claims, avoiding duplications of tests, educating patients on what situations require an emergency room visit, a medical aid visit, or contacting their physician after hours can help reduce cost. Also, another one I like to do is managing you chronic care patients with a structured plan of care to reduce incidence of hospitalization. Quality insights is here to help you. We can discuss workflows to see if there are areas to improve of better monitor your patient. We can walk you through the MIPS feedback report and highlight areas you may be able to focus in on, improve. Don't hesitate to reach out to us. Next please. Next slide.

These are some resources that we have put here for you, check your eligibility status. That's a quick one, you don't need an EIDM account you can go there, look it up. Then, this is how to set up and access an EIDM account. This is our annual wellness visit toolkit if you're not already doing them this is a guide that can help you. The cost fact sheet. A lot of the information we provided today is contained in this CMS cost fact sheet and it's good piece of material to refer back to occasionally. The QPP year two final rule, if you want to find out more about it, read what is all included in the 2018 MIPS rule by using this link which this will take you to that document. Next slide.

Okay, questions? I'm going to ask Laurie to see if there are any questions out there that you have at this time.

Laurie Fink: Thank you, Rox. Yeah, I wanted to apologize. We've had a couple people chat in that they're having some audio issues that it cut out here and there. Not sure what's causing that, but if there's a particular slide or topic that we went over and you weren't able to hear, just let us know and we can go back to that slide and talk you through that if you missed it. But, if you have any other questions for our team I encourage you to go ahead and type them into the chat or the Q and A box on the right of your screen. If you already submitted a question during the presentation it will be addressed now as time permits. I did see a couple questions roll in so I'll start reading those off and anyone on our team that's on the panelist list feel free to jump in and answer the question.

The first question is from Terry. She asks, "When verifying participation status, I have a PA listed as exempt. Why is that?"

Roxanne: Hi. This is Roxanne. The PA is listed as exempt because she is below the threshold of $90,000 in billing or less than 200 Medicare patients. That would make her exempt, not eligible for this year. Now, again, this is an opportunity that you can look to see if it's more valuable to report as a group and that way she would be included in that group and could receive incentive.

Laurie Fink: Okay. Terry has a follow-up question. She says, "We are a specialist. We need to make sure the patients see their PCP, which will help drive costs away from us. Does it matter if they see us first or not?"

Roxanne: Usually if you're a specialist the primary care would do a referral to you. It just depends, sometimes they may have had a conversation with their practice, their doctor over the phone and he encouraged them to go directly to the specialist, but in most cases we see where this primary care would refer them.

Laurie Fink: All right. The next question asks, should specialists bill only specialty diagnosis? We don't add co-morbidity diagnosis? For example, bill UTI only and not report heart disease, high BP, et cetera?

Julie Williams: This is Julie. I'll take that. You want to bill ... If they're there for just a UTI of course you're only going to bill the UTI, but if they do have any chronic conditions that would factor into that like diabetes or something like that or if they have this reoccurring you would want to add all of those codes that would affect them.

Laurie Fink: All right. Our next question is from Barry. He asks, "Will physicians who have access to their QRUR now automatically have access to the MIPS feedback report or must they request for the new report?"

Julie Williams: This is Julie. I'll take that again. If you have the EIDM account you should be able to get your feedback report for that. We're still waiting for that to come out with all the details, but that they say is where you'll be able to access that. Yeah. If you have access to get your QRUR then yes you'll have access to get your 2017 feedback report.

Laurie Fink: Our next question is from Evelyn. How does coding affect the RAF?

Julie Williams: Well, this is Julie again. Coding is going to affect it because you want to let Medicare know how sick or how well your patients are. They're going to adjust your risk scores to the health of your patient. If you're not coding and everything is kind of inconclusive on your codes and they're not specified then they're not really going to get a picture of your patient. It's important that you do that so they'll know the true level of health of your patient.

Laurie Fink: All right. Next question is from Beth. My providers individually do not qualify, but as a group they do report, which way should we report?

Roxanne: Definitely report as a group. This way you have an opportunity to get at least a slight incentive increase in your Medicare reimbursement.

Laurie Fink: All right. Our next question comes from Paula. She says, "We are a multi-specialty practice. How is the patient attributed to the TIN or NPI?"

Julie Williams: By how much care do you provide that patient. If you provide more care to that patient then their other doctors then that is how that patient is attributed to you.

Laurie Fink: Okay. Our next question is from Barbara. What if the patient refuses to follow up with their primary care provider?

Roxanne: Unfortunately, it's sometimes harder to try to control the patient so you can just continue to just strongly encourage them to see their PCP, but that's really all you can do and hope that they'll finally get the understanding that it is important that they have someone managing your overall healthcare and that's the role of the PCP.

Laurie Fink: Next question comes from Evelyn. She's from a specialist office and she asks, "What about coding patient's family history, such as history of cancer, diabetes, et cetera?"

Roxanne: If it's relevant to their care, absolutely.

Laurie Fink: Okay. Next question is from Paula. How many diagnoses codes does Medicare accept per claim? Also my providers feel they shouldn't be coding if they are not treating the patient for those specific illnesses, what is the best practice regarding coding?

Julie Williams: Well, of course we'd only want them to code things that were relevant to their type of practice. But, their chronic conditions would be relevant because if they did have a chronic condition they may treat the patient in a different manner. Those would be how it would be affected to those patients. If the patient has diabetes you're not going to give them certain medications. The same thing will heart disease. Of course, those are chronic conditions that would raise your patients risk score and also let Medicare know the level of care and treatment that you're providing your patient. In Medicare I believe will let you submit eight diagnoses with the new form. A lot of it has to do with your clearing house unfortunately, so it's hard to answer that. You can add as many as you want. It'll start a new page, but sometimes your clearing house will drop those. That's something that you'll almost have to check and see if your paper, you can send numerous pages, but if you're not paper if you're electronic it'll just end on your clearing house.

Laurie Fink: Okay. Another couple questions came in. What do PCP's do about non-compliant patients who've been attributed to their QRUR via ED visits?

Roxanne: It's Roxanne again. I've had practices that have had this happen. There are a couple things. Until they see another PCP they are still attributed to you or if they start going to a specialist and seeing them on a regular basis, but they would have to be seeing another physician or care under their care to have that attribution be removed from you. But, I have had cases where the patient has not gotten a new PCP and continues to use the emergency room. All you can do is reach out to the patient, contact the patient and encourage them if they may be relocated to try to find a PCP in that area or even I've had practices go to the

extent of even giving them information of doctors in a new area that they've moved to just to encourage them to establish new care.

Laurie Fink: All right. Our next question asks, for documentation purposes as a specialist do we just indicate in the SOAP that the patient was advised to see his PCP?

Julie Williams: Absolutely.

Laurie Fink: All right. That was a nice short but sweet answer there. Next question, this is from Carrie. Just to clarify a specialist should not code chronic conditions unless they effect what they are seeing the specialist for? Is that correct?

Julie Williams: Sorry, I had myself muted. That is correct. The big thing is you definitely want to code and if anybody wants to follow up and we can talk in detail, feel free to reach out to us and we'll be happy to, but you definitely want to code and let Medicare know of course the health of your patient. If it isn't relevant to the scope of care that you're providing of course you're not going to code it, but some of these chronic conditions could be.

Laurie Fink: Will the cost category performance data be available on the QPP portal?

Roxanne: Yes, the cost information will be available in the MIPS feedback reports; both the preliminary reports available now and in the final reports expected in July, 2018.

Laurie Fink: All right.

Julie Williams: Also, next year you'll also be able to get that on your feedback report which we'll all be dying to see, but right now if you kind of wanted to look at your costs and kind of see where you were previously to MIPS you could definitely go back and look at your QRUR, which will give you a better idea that'll actually drill down to that patient level. You can actually see the cost of one patient will mess up your whole adjustment score there, so you're going to want to look at that. That will be a great report to look at just to see where you stood before this all started and how you're improved over time.

Roxanne: Also I just want to add, too, if you've never accessed your QRUR report and you need some guidance we are here to help you.

Julie Williams: We see that the question is there an appeal process to get that beneficiary removed? We only really wish they were. Unfortunately, by the time that process goes through they'll probably already be dropped off. We have never seen anybody have any luck getting this done. I haven't, have you Roxanne?

Roxanne: No, I haven't.

Julie Williams: Yes. It all depends on getting that patient into their primary care to get some care.

Laurie Fink: Okay ladies. There's a question from Evelyn. She's asking, "Is there a way to let Medicare know if a patient refuses to answer questions on a reporting measure?"

Julie Williams: There's probably an ICD-10 code for that. Saying that the patient is being difficult in some certain words there, but non-compliant in a way. There is an ICD code for a non-compliant.

Laurie Fink: Okay. Candace is asking, "We are a pain specialist and some of our patients have both behavioral health issues as well as codes for things like diabetes et cetera. Can we use these codes as well as our pain codes?

Julie Williams: Yes.

Laurie Fink: Okay. I believe we've addressed all the questions. We'll go ahead and wrap up today's session. Thanks so much to Roxanne and Julie for their great presentation on the cost category and thank you everyone for joining us today. We want you to know that quality insight is here to help you navigate MIPS and the quality payment program. Our assistance is funded by CMS, so there's absolutely no cost to you to take advantage of our services, our huge library of resources and also educational sessions like this one today. We hope you found this to be an informative and beneficial presentation. When you close out of today's session you will be automatically directed to a very brief evaluation. We ask that you please take a moment to complete it. We greatly appreciate your feedback and comments. Thanks again. Have a great rest of the day and this session has now concluded.

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