Quality Insights
Quality Payment Program Support Center

Managing Patients with Hypertension under the New MIPS Guidelines Transcript from Live Webinar

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Laurie Fink: Good afternoon and welcome to today's webinar, Managing Patients with Hypertension under the New MIPS Guidelines. My name is Laurie Fink and I'm a communications specialist with Quality Insights. I'll be serving as the host for today's session. We will get started with today's presentation in just a few moments, but first I'd like to review a few housekeeping items. All participants entered today's webinar in a listen-only mode. Should you have a question during today's presentation, we ask that you please type it either into the chat or the Q&A box to the bottom right of your screen.

Laurie Fink: We will not be hosting a formal Q&A at the end of today's session, but please know that if you do submit a question to us, we will get an answer back to you via email after the presentation. Today's webinar is being recorded. The recording, along with the slide deck, any transcript of the webinar will be posted on the Quality Insights website as well as the Quality Insights QPC Support Center website as soon as possible. These resources can be found on the Archived Events page.

Laurie Fink: Joining us today to talk about managing patients with hypertension under the new MIPS guidelines is Clayton Marquiss and he joins us from Healthcare Dynamics international. Without any further ado, I will now hand the presentation over to Clayton.

Clayton Marquiss: Hello everyone. I hope you are all staying warm today on this cold day on the East Coast. We are going to jump right in on Managing Patients with Hypertension under the New MIPS Guidelines. I'm sure you are all familiar with MIPS. It's the merit incentive based performance. It's the Merit-based Incentive Payment System. It's one of the two tracks under the Quality Payment Program which takes Medicare Part B to a performance based system instead of just the single payment system where all Medicare is trying to evaluate payment. That is the goal of the MIPS.

Clayton Marquiss: In 2019, MIPS did have a few changes. They added some providers as you can see. They added a few more eligible clinicians; the PT, OT and Speech Language

Pathologist, also audiologists, psychologists and dieticians. These are in addition to all the other clinicians that are already added to MIPS. Another change they did, they increased the threshold for avoiding penalty. So if you want to keep the same payment, or a payment to go up, you have to have an additional 15 more points this year. Last year it was only 15 points and now it's actually 30 points, so it has doubled. I'm not going to go into how you get all the points today, but there is a vast spreadsheet of how you can obtain points. You can also get points by meeting the hypertension measure which we will go into momentarily.

Clayton Marquiss: There also is a higher payment adjustment system. Last year I think it was at 4% (Clarification: the payment adjustment for 2018 is 5%) you could lose or gain 4%. This year you could theoretically lose 7% or gain 7% in the 2021 payment year because the payment year is two years from the actual year end, two years away. They also added some more low volume exclusions. Not every clinician is part of MIPS. If you're a very small clinician, or there things that exclude you, this year they added if you have 200 or fewer threshold services out of the PFS, that will exclude you from MIPS. They also went to a single MIPS determination. They extended the period of MIPS for an additional 12 months. As you can see below, it was from October 2017 to September 2018. They've now added another 12 months section onto that.

Clayton Marquiss: They've changed some of the modified performance category weights. Last year it was only 50% quality and that has gone to 45% and cost has gone up by 5%. So 5% was taken from quality and that was added to cost because we are trying to minimize cost for CMS as much as possible. All the other category weights stayed the same. There is a few reporting requirements they got rid of. CMS removed 26 of them that they found to be duplicative. Almost everyone was reporting on them and doing very well. Some of them had 99% rates for compliance. So whenever their rate was that high, CMS decided to get rid of that measure and to add a new measure.

Clayton Marquiss: As you can see, there are eight new measures. A lot has to do with functional status and some has to do with DEXA scans and vaccinations as well as HIV screening. MIPS can be overwhelming to certain small practices, but they do add assistance for various small practices. So they're going to continue to help with the small practices and these are some bonus things that they added in 2019. The small practice bonus will be in the quality performance bonus and they increased the bonus to 6 points from 5 points. You'll still get 3 points even if you don't complete the measure, but you attempted to complete the measure. There's now an opt-in policy. Certain providers are not included in it, but they can opt in if they wish.

Clayton Marquiss: There's also now multiple submission types along with electronic system and those submission types are, in various ways, you can have a CMS portal and you can actually submit your things online instead of on paper. (Clarification: The CMS Quality Payment Program Portal is online and accepts attestation or file uploads. There is no option for paper submission for MIPS). Here is a brief guide

to all the MIPS changes in 2019. It's basically adding more clinicians, every clinician must earn 30 MIPS points as opposed to the 15 of last year. The categories shifted a little bit more to cost. And they removed some measures and they added the small practice bonus and the opt-in. Now we are going to jump right in to hypertension. I'm sure you're all very familiar with hypertension. It is a plague in the United States of America due to a certain diet that we have and it's also caught around the world.

Clayton Marquiss: But, I could not imagine that no one on this call does not know someone who is dealing with hypertension. Hypertension is, you can't see it, but you can feel it sometimes. It sometimes goes undetected and some people do not know they have it. As you can see on the slides, one if three people with hypertension, they don't even know that they have it. That is a very serious disease process that we have to get under control in America. It also drives costs out the roof. It's the highest utilization in a prescription drug. Of all the drugs in America, the highest use of them is for hypertension.

Clayton Marquiss: It obviously is an issue that we need to get under control. Only 54% of the people with hypertension actually have their BP under control, which is less than 140 over 90. One out of three Americans have pre-hypertension. Two out of three Americans either have pre-hypertension or hypertension. That's 57%. It's a very high number. There are two types of hypertension. There's primary, and that develops gradually over time. There's secondary, which is caused by some kind of condition you have. Sleep apnea, having renal issues, certain tumors on your adrenal gland and certain congenital heart defects could lead to hypertension. It could also be done by drugs or prescription drugs as well.

Clayton Marquiss: Here are some risk factors for hypertension. African-Americans have a higher risk, people with a family history of hypertension. If you're older. If you're overweight or obese, smoking tobacco can greatly increase hypertension risk. As well as sodium in your diet. One very simple way to lower your risk of hypertension is to not add salt to your food. Consider adding herbs or other things, but salting your food in excess can definitely cause hypertension. Hypertension is detrimental to our health. It can cause heart attacks, aneurysms, heart failure. It can cause your arteries to thicken. It can cause dementia in the late stages, but it's a very serious situation. One thing about blood pressure is, when you're at the clinic and you're getting your blood pressure taken, the most important part in the beginning is getting the correct reading.

Clayton Marquiss: I'm a nurse. I've taken thousands of blood pressure readings in my time, in my clinical time. But some patients, they get their blood pressure taken and it's not always accurate. Sometimes the MA is taking it. Maybe the MA is not trained very well, maybe they're new. Maybe they haven't been re-trained in years. One essential piece to hypertension is ensuring that all the clinic staff knows the proper way to take a blood pressure. You can find all the steps to take the blood pressure, but there are guides out there. There are textbooks that you can go through. I would recommend having your staff re-trained often on blood

pressures and if you're ever at the high readings, always re-take it. Perhaps the physician re-takes it, or the provider re-take it.

Clayton Marquiss: So you know right there what it is. There also are trainings in this field so you can get a double headed stethoscope that you can hear the blood pressure while they're doing it to confirm that they are getting the accurate reading that they are reporting. Develop a BP competency assessment tool, there are a lot of things online that you can get for free. It just goes into how you take a blood pressure. You let them rest. You put the cuff firmly on their arm. Make sure the stethoscope is right above the AC space. Make sure you're not inflating it too fast and not too slowly. Make sure it's a constant rate.

Clayton Marquiss: There's a lot of different ways that you can assess the competency of all of your staff. It's the whole clinic's responsibility to talk about this with patients. Some patients, they get along really well with Marsha the nurse. So Marsha telling Mrs. Smith that she has hypertension, that she needs to reduce salt, exercise more, that information might be received so much better by the patient than the PCP telling that patient because the patient likes Marsha. They've seen Marsha for 10 years at this clinic. So it's the whole clinic's responsibility for them to take a look at how they respond to certain things to see what staff member may be the most appropriate to help educate them.

Clayton Marquiss: The more education the better. Sometimes in the EMR, you can add certain adjustments and that can really help physicians. The physicians or provider is seeing 15 patients a day, sometimes more. Having different EMR modifications to assist that provider, to see trends, is very, very, very helpful. It's so much easier to see all of them across a spreadsheet and also I'd recommend having them bolded, especially if the blood pressure is not normal. Have it bolded. Consider having it black for normal, yellow for pre-hypertensive and red for hypertensive. It very much helps to bring this important feature out to the provider. Whenever a patient is in your office and they get that first high blood pressure reading, either hypertensive, pre-hypertensive, it is important right then to begin the education.

Clayton Marquiss: They have hypertension. You hand them that pamphlet. You give them an iPad with a website that shows a video on it. You can give them papers of some sites. You can text them websites. You could email them websites. You can just explain to the patient what hypertension is and what their level is and why it's important to modify their lifestyle or to effect change. Once the hypertension reading is observed, it is key to tell the provider in person, or through some kind of note. Obviously they're going to put the BP reading in the chart, but giving the provider that little extra, "Hey, Mrs. Smith. She's in room two and she has a hypertensive reading today," or, "She has a pre-hypertensive reading." It gets the provider narrowed down to the problems that are facing that patient and it really helps just to have a workflow that they can tell the doctor in person.

Clayton Marquiss: Again, patients have different rapport with different providers or different staff members. So it's important to know which staff members the patients trust or

wants to talk to and that might be the best person to enact change for that patient. Here's the things we talked about earlier, just different things that the practice can do for QI inventions during the patient appointment. They can confirm the BP. If a patient has a high blood pressure I would always recommend that there is a confirmation blood pressure check. Do not do it right away. You should give the patient about two to three minutes to rest.

Clayton Marquiss: You shouldn't do it right back to back. But, you definitely should recheck people's blood pressures that are elevated in your clinic. Then you'll have more than one data point, so you'll see possibly the person was wrong, possibly the person was a little bit off. It's great to have as many data points as possible and for MIPS, you use the most recent one. So if you took three blood pressures in that meeting, or that clinic visit, the most recent one is the one you have to report for MIPS. Having the patient be involved in the plan. Explain to them what hypertension is, what modifications they can make.

Clayton Marquiss: Have the patient try to self-activate and try to get them to tell you what they are going to enact to change with their lifestyle. You sitting there and telling them eat less salt, exercise, don't eat fatty foods, and don't eat dressing. That's great, but having the patient verbalize it just, it increases their compliance so much more. It helps them self activate. Just have them try to repeat the action steps they will take to try to lower their blood pressure. A BP log is huge. The patient can have a BP log at home and bring it to the doctor the next time they come. That's going to really show the doctor any trends they're having, if they're sloping up, if they're sloping down. You can get automatic blood pressure cuffs at any pharmacy. They just fit on your wrist.

Clayton Marquiss: If they are used correctly, they can have great readings and do great things. If they're used incorrectly, they can get bad readings and probably scare the patient, too low or too high. So if the patient does do a BP log, ensure they are getting a blood pressure cuff that works and they know how to use it. I would even recommend them bringing the blood pressure cuff into the practice so they can do a reading on that and they can do a reading with the doctor to make sure they are similar and the patient for sure knows how to do the blood pressure cuff. If you're doing an automatic cuff, you put it on your wrist and you hold that hand against your chest to your heart. But there are different types and different practices for it.

Clayton Marquiss: The next slide talks about just the blood pressure MIPS quality ID. So there are many different quality IDs and this one is 317 and it's basically follow-up documentation for blood pressure. In MIPS, they want any patient to come in who is 18 years old or older to get a blood pressure check who does not already have an active diagnosis for hypertension. If they're normal, then there's no follow up. If they are high, then you have to do certain things and document certain things to ensure compliance with MIPS and to get that quality payment. So people that have active hypertension, they are not eligible for this.

Clayton Marquiss: People under 18, they are not eligible. Again, the BP must be the most recent BP in that visit and the blood pressure has to come from the office staff. You can't report from somewhere else and so, "OH, the hospital said this is the blood pressure." The blood pressure must be taken that day at the clinic. There's four different kind of BP readings in this MIPS quality measure. There's normal, below 120 over 80; pre-hypertensive, which is basically between for systolic, between 120 and 139 and then 80 to 89 for the diastolic; first hypertensive is above 140 and above 90; and second hypertensive, they're having that same reading within the last 12 months. To be second hypertensive, you have to have two encounters to be documented second hypertensive.

Clayton Marquiss: Here's the follow-up for all those four different classifications. If you're normal, no follow-up is required. If you're hypertensive, they have to refer you to an alternative or primary care provider and recommend lifestyle changes. Pre-hypertensive is similar, but it's a much sooner follow up. And second hypertensive is similar to pre-hypertensive, but you also can have one of the lab therapies, like medicines or laboratory tests or ECG. These must be documented. If you tell a patient yes you are hypertensive, come back in a year and you do not document that that happened, that you had a discussion and you said follow up in a year, you will not get reimbursed for that. This is all about documentation and follow up. It is essential you do it.

Clayton Marquiss: It's also essential that you document if they refuse it. Here are a few of the lifestyle modifications. On the left side are broader brush strokes; weight reduction, the DASH plan. If you're not familiar with that, it's all over the internet along with a lot of the nursing materials and provider materials. It's a diet plan to help you eat less salt, just reduce salt in general, increase activity and limit alcohol. On the right hand side are just some easy things to help you cut back on things. Eat foods lower in salt, lower in calories. Use skim milk opposed to whole milk, eat more vegetables and fruits. Eat plain rice and pasta. And try to use flavorings and spices as opposed to salt. And as always, try to limit your butter, margarine and salad dressing and salty snacks.

Clayton Marquiss: As we previously talked about, people that are not eligible for this screening: people who have active hypertension diagnosis, people who refuse the BP measurement or the follow up, or people who are under 18. Refusals must be documented. If a patient refuses and you do not document that, that patient will be counted in the denominator and will greatly affect your percentage and will put you on a lower depth file to get lower points. We want you to get credit for every one that you take care of. Everyone that you see and you're recording that, we want you to get all the credit for that. So it's important you write the follow up and you write the refusals in the chart. One person who would be excluded from this is if someone comes into your clinic and they have a very, very, very high blood pressure and it's an emergent situation and they probably are going to end up going to the hospital. That patient will be excluded.

Clayton Marquiss: That patient needs to get care immediately. But you must document what happened and where you sent them and what the follow-up was. All the

patients who are 18 years old or older, do not have an active hypertension diagnosis and went through one of these CPT codes. Whether you're screening, or wellness exams. Some of them are not covered by Medicare, but that should still be included if they are done for the patient. So basically it's a simple fraction. You divide the number on top, how many patients you were able to accurately screen and follow-u, and the bottom is your total number of patients. It's a pretty easy formula.

Clayton Marquiss: These are different codes that you put in whenever you actually report to MIPS. So if they are normal, you put G8783, pre-hypertensive is there. There's different ones for refusal. So this is how you actually report it in HCPCS codes. This is just a flow sheet of how it all goes in. The denominator and the numerator in the equation. Here's a sample of that decile calculation. This practice is actually doing pretty well. The first one is data completeness and the other one is the performance. They have nine out of ten patients as great. Then five out of seven in the actual performance rate.

Clayton Marquiss: So the performance rate is what would be counted for your MIPS score. So if you do this measure for MIPS by CMS, is you report it for less than 60% of patients. It's probably the best rate, less than 50%. You'll still get three points. They're giving you three points for attempting to complete the measure, which is great. Any points are good points if you attempt it. So small practices only get three points for that 60 and a large practice would only get one point. The difference between a small and large is 15 clinicians. (Clarification: Small practices have 15 or less Eligible Clinicians, Large practices have 16 or more Eligible Clinicians according to the CMS final rule.) So if you have 15 or more clinicians, you're considered a large practice.

Clayton Marquiss: So if you report at least 50% of your patients, but you only have less than 20 cases, then you'll still get three points because you did 50%, but you have a very small number of patients. If you're able to do it for 60% and at least 20 patients, the chart below shows you what your points would be. So it's possible to get 10 points for this. All you have to do is, well, that would be 100% of your patients. It would be pretty difficult to do 100 I believe, but it is very possible. I think having anything above six points is great here for the practice. That will be 6 of those 30 points we previously mentioned. That's already one-fifth of your points for the year for that MIPS provider.

Clayton Marquiss: Patient engagement is essential in hypertension. As I mentioned previously, hypertension, you can't see it. You can actually feel when you might have a headache, but usually with hypertension, you cannot physically see. Someone has a tumor, someone broke their arm, you can see it right there. Hypertension is hidden and it's very important for the patient to work to improve their hypertension. There has been many studies about patient engagement over the years and when patients are engaged and they're with their provider and they're in a cooperative team, they always do better. Always, always, always. Having the patient, encouraging the patient, having them do their own BP at

home, it kind of gives them some autonomy, it helps them feel like they're helping the situation which is great.

Clayton Marquiss: Patient activation is key here. Sometimes explain to a patient what hypertension does to the body. You're all probably familiar with how the kidneys work and how blood pressure pushes your blood through the kidneys, but when you have high blood pressure and it's forcing that blood through the kidneys, it damages your kidneys. Some of the might not know that. So if you explain to the patient having hypertension is going to cause strokes, it can cause one of your blood vessels to rupture and then that will be leaking in your body. So if you explain to the patient the actual physical attributes of what hypertension does, it somehow gives them more of an incentive. They're like, "Well, I don't want my kidneys to blow out. I don't want my blood vessels to break."

Clayton Marquiss: So explaining to them really how hypertension hurts you can just increase patient activation and make them aware that it's a very serious health issue. That's about all that I have for today, but one thing I would encourage all of you to do is talk to other practices, talk to your provider friends. Ask them how they're monitoring blood pressure. See if they have any special things they're doing that's working. I think that talking to your peers and talking to other clinics is a great, great way to get other resources and other options for treating patients with hypertension because hypertension really cross all measures. I would recommend talking to other practices, seeing what works for them, what doesn't work and having a dialogue with your peers really can assist getting these measures met. And that someone might think of something that you never thought of. It might seem simple, but they enacted it and it increases their measure by 10%.

Clayton Marquiss: That's huge. Huge for the patient, huge for MIPS, huge for the providers. That's about all that I have today. If anyone has any questions, you can type them in the bottom right. Laurie will make sure she gets to them and if she needs any of my insight, she will reach out to me. We will for sure get your questions answered, I believe within the next week, we can email you the answers. We have about two minutes left. These slides will be sent out and available to you. Here's a little bit about me. I've been a nurse most of my life and I now am working in administration and I'm very, very passionate about the incentive based payment.

Clayton Marquiss: It's been a fee-for-service forever and now we're going to incentive based and this is going to get providers richer and patients healthier if they can keep the patients healthy, which they will be able to. In the past, ever since humans existed, we've all been doing a fee-for-service. In the last two or three years, CMS has really understood that their costs are going to skyrocket unless they figure out a way to keep patients healthier. Incentivizing the providers is a great way to do it. I think it's going to help everyone along and it hopefully will save trillions of dollars to CMS over the next 50 years.

Clayton Marquiss: That's about all I have for you. Thank you all for joining this webinar and I look forward to seeing all of your results in the upcoming years for MIPS. Thank you.

Laurie Fink: Thanks Clayton. This is Laurie again. Thanks everyone for joining us today. I just wanted to bring your attention that we are having another webinar tomorrow. Quality Insight is hosting a webinar at noon and its entitled, ***2018 MIPS Data Submission Overview***, as we are now in the data submission period. We have some great tips for you and can walk you through the data submission process. So we invite you to join us tomorrow. Again, that's at noon. I did post the registration link in the chat. You can just click on that and register to join us. If your chat box isn't open, it's real easy to get to. Just drag your mouse onto the screen. There will be a little menu bar that pops up at the bottom and there will be a speech bubble, a blue circle. Click on that and it will open your chat and take you right to the registration link for tomorrow's session. Thanks again everyone for joining us today. Thanks so much to Clayton for being our speaker and providing us with very valuable information related to hypertension and the MIPS program. Have a great rest of the day. This session has now concluded. Thanks.

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