Quatris Healthco

Leveraging Chronic Care Management (CCM) to Improve MIPS Performance

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaces the Medicare Sustainable Growth Rate (SGR), which was how CMS previously controlled the cost of Medicare payments to physicians.

MACRA is aimed at strengthening Medicare access and improving physician payments, among other improvements.

Out of MACRA is the Quality Payment Program (QPP), which streamlines several pay-for-performance programs in the new Merit-based Incentive Payments System (MIPS) and provides incentive payments for participation in Advanced Alternative Payment Models (APMs). Payment adjustments start out at +/-4% in 2019 and increase up to +/-9% by 2022 and continue at that rate for several years after.

MIPS replaced the PQRS (Physician Quality Reporting System) and MU (Meaningful Use) criteria.

2019 MIPS eligibility is determined by clinicians:

- Identifying on Medicare Part B claims as a MIPS eligible clinician type
- Enrolling in Medicare before 2019
- Not being a Qualifying Alternative Payment Model Participant (QP)
- Exceeding the Performance Year 2019 low-volume threshold
- As an individual when reporting individually, or
- At the group level by being in a practice that exceeds the low-volume threshold when reporting as a group or virtual group, or
- As a MIPS APM participant that exceeds the low-volume threshold at the entry level

Additionally, the definition of MIPS eligible clinicians was expanded to include additional clinician types:

- Physical Therapists
- Occupational Therapists
- Qualified Speech-Language Pathologists
- Qualified Audiologists
- Clinical Psychologists
- Registered Dietitian or Nutrition Professionals

In 2019, there are four MIPS performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability. For the majority of MIPS eligible clinicians, the percentage breakdowns for the final score are as follows:

- Quality: 45%
- Cost: 15%
- Promoting Interoperability: 25%
- Improvement Activities: 15%

About RevUp Chronic Care Management

The RevUp technology, services, and analytics produce scalable, high-touch care models that enrich the patient-provider experience and reduce the cost of care.

The RevUp platform delivers real, measurable improvements in health outcomes and lowers healthcare costs.

See more at:
https://www.quatrishealthco.com/chronic-care-management-services/

Controlling for Quality with Chronic Care Management (CCM)

A Chronic Care Management (CCM) program fully supports the Quality metrics necessary to maximize incentives and minimize penalties under MIPS. The specific quality metrics supported will be practice and specialty dependent.

Below are illustrative examples of MIPS metrics that can be met by having a CCM program:

- Controlling high blood pressure ("Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period")
- Hypertension: Improvement in blood pressure ("Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.")
    - Health coaches can access the patient's diagnoses via the EMR/EHR and collect patient-generated blood pressure data via telephone, text messaging, and MD Revolution's proprietary mobile and web applications. This information allows health coaches to monitor and report the percentage of patients whose blood pressure has either been under control or has improved while enrolled in the CCM program.
- Body mass index screening ("Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter Normal Parameters: Age 18 years and older BMI □ 18.5 and < 25 kg/m2")
    - Similar to blood pressure noted above, body mass screening can be easily performed via similar procedures.
- Preventive care and screening: Influenza immunization ("Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization")
    - Health coaches document patient-reported information regarding influenza immunizations, and can access electronic health records to validate the information for MIPS reporting.
    - All reporting on influenza and other screenings will be predicated upon patients enrolling and participating in the CCM program. Accordingly, patient and provider engagement with CCM services will be central for success within MIPS.

CCM is an excellent steppingstone into MIPS. Both programs share Medicare's goals for physician payment reform and value-based reimbursement models.

Plus, CCM and MIPS share many programmatic features, such as developing and following a comprehensive care plan, performing medication reconciliations, and managing transitions of care.

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Below are illustrative examples of MIPS metrics that can be met by leveraging our turnkey CCM solution, which will provide both the technology and service elements to ensure your patients get appropriate screening and documentation within the provider's electronic health record.

- Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use ("Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use"
- Breast Cancer Screening ("Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.")
- Colorectal Cancer Screening ("Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.")
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment ("Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified")
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan ("Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen")
- Diabetes: Eye exam (“Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period”)
- Diabetes: Hemoglobin A1C poor control (“Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period”)
- Diabetes: Medical Attention for Nephropathy ("The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.")

Starting a CCM program – either in-house or through a partner – can help a practice create the proper infrastructure to ensure full compliance with MIPS.

That’s because CCM provides an opportunity to strengthen ties with patients, improve their outcomes, and in general, position the practice for bigger wins in the future.

Practice Improvements are fully enabled for MIPS through a CCM service

- Chronic care and preventative care management for empaneled patients ("Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning; use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target; use pre-visit planning to optimize preventive care and team management of patients with chronic conditions; use panel support tools (registry functionality) to identify services due; use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or routine medication reconciliation.") a little bit of body text

- Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.
    - Health coaches discuss the prioritization of care plan goals with patients and/or caregivers via the telephone.

- Engagement of patients through implementation of improvements in patient portal ("Access to an enhanced patient portal that provides up to date information related to relevant chronic disease health or blood pressure control, and includes interactive features allowing patients to enter health information and/or enables bidirectional communication about medication changes and adherence.")

The RevUp online app is constantly evolving and improving. It contains clinically relevant education, provides an overview of patient-generated data, allows access to individual care plans, and enables secure digital communication to occur between patient and chronic care professional.

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According to CIO magazine, "CCM provides poly-chronic patients with the level of care necessary to keep them well and minimize preventable utilization, which is critical under MACRA.

CCM also subsidizes the foundational technology and operational capabilities necessary to succeed under MACRA, such as interoperability across all care settings, asynchronous patient communication, and better care management methodologies."