MACRA - Impact to a Vascular Surgeon’s Practice: Tools for SVS Members

BRAD JOHNSON, MD
PROFESSOR OF SURGERY
DIVISION OF VASCULAR SURGERY
Financial Disclosure

- I have nothing to disclose
“Massive training is required to instill the courage to break with tradition.”

-W. Edwards Deming
Recipient, Julius H. Jacobson II Award for Physician Excellence

Initiated the first five-year residency program for vascular surgery training.

Organized the Vascular Study Group of New England (VSGNE) regional consortium
VSGNE 2013
30 Participating Hospitals

15 Community - 15 Academic

>38,000 Procedures Reported
CEA, CAS, oAAA, EVAR, LEB, PVI, TEVAR, Access
Working to Prepare for MACRA

SVS President

SVS Executive Committee

QPMC

Governance

Coding

Key members

Key members

Key members
Definitions

- CMS released the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 on April 27th 2016. Renamed it the “Quality Payment Program.”

- Proposed rule establishes framework for transitioning to the Merit-based Incentive Payment System (MIPS), which consolidates the existing Physician Qualified Reporting System, Electronic Health Record Meaningful Use, and Value-Based Payment Modifier programs under the current Medicare Physician Fee Schedule.

- Proposed rule - specifics on how CMS will determine whether payment models meet the “Advanced Alternative Payment Model” (APM) criteria needed for receiving bonus payments and exemption from MIPS.
Starting in 2017, physicians will have to **choose**

Stand in Place (and lose money)
Starting in 2017, physicians will have to choose to stand in place (and lose money) or choose MIPS or APMs.
Impact to a Vascular Surgeon’s Practice: Tools for SVS Members

- Examples of how SVS members use protocols, registries and outside services to meet current quality reporting requirements
- Who is responsible and how to ensure quality reporting
- How is VQI a part of the tools and solutions for SVS members
- Understand the role of SVS clinical practice guidelines
- SVS Alternative Payment Model Development and Quality Reporting
How are SVS members meeting reporting requirements?

Vascular Quality Initiative® vs. Deloitte.
“MACRA is a game-changer. It was designed to disrupt our health care system at all levels. And it’s doing just that: MACRA is already creating strategic discussions around new care, payment, and delivery models. In this case – and especially given the tight deadline – it is time for all to hop on this fast moving highway.”

Anne Phelps, Principal, US Health Care Regulatory Leader, Deloitte & Touche LLP
# Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule Updates</th>
<th>Quality</th>
<th>Resource Use</th>
<th>Clinical Practice Improvement Activities</th>
<th>MIPS Payment Adjustment</th>
<th>Certain APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 and earlier</td>
<td>0.5</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td>Qualifying APM Participant</td>
</tr>
<tr>
<td>2016</td>
<td>0.5</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td>Medicare Payment Threshold</td>
</tr>
<tr>
<td>2017</td>
<td>0.5</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
<td>Excluded from MIPS</td>
</tr>
<tr>
<td>2018</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>0</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>2021</td>
<td>0</td>
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<tr>
<td>2022</td>
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<td>2023</td>
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<tr>
<td>2024</td>
<td>0</td>
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<tr>
<td>2025</td>
<td>0</td>
<td></td>
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<td></td>
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<tr>
<td>2026 and later</td>
<td>0.75</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Qualifying APM conversion factor

**Non-qualifying APM conversion factor
MIPS Reporting

- First MIPS reporting period begins on January 1, 2017 and runs through December 31, 2017.
- MIPS Eligible Clinicians: Physicians, PAs, NPs, CMS, CRNA
- For applicable clinicians, 2017 MIPS performance will determine payment increases/penalties for the 2019 Payment Year.
- Maximum MIPS negative payment adjustment will be -4% for 2019.
- Three major categories of exempted physicians:
MIPS Composite Scoring Scales

- Clinical Practice Improvement Activities: 15%
- Advancing Care Information: 25%
- Cost: 10%
- Quality: 50%
25% Advancing Care Information:

- Clinicians will report key measures of interoperability and information exchange.
- Clinicians are rewarded for their performance on measures that matter most to them.
  100 points
25% Advancing Care Information:

- Clinicians will report key measures of interoperability and information exchange.
- Clinicians are rewarded for their performance on measures that matter most to them. 100 points
- What mechanism will we use to keep track of these measures in our practice and how will we report them?
15% Clinical Practice Improvement Activities:

- Clinicians can choose the activities best suited for their practice
- Proposes over 90 activities from which to choose.
Clinicians can choose the activities best suited for their practice.

Proposes over 90 activities from which to choose.

How do we track and report these activities?
10% Cost:

- CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.
- Average score of all resource measures that can be attributed.
10% Cost:

- CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.
- Average score of all resource measures that can be attributed.
- *Will CMS tell each Vascular Surgeon what this value is for them?*
Clinicians choose six measures to report to CMS that best reflect their practice.

Participating in VQI meets the Quality requirement.
<table>
<thead>
<tr>
<th>Measure Title</th>
<th>NQF</th>
<th>PQRS</th>
<th>Measure Description</th>
<th>NQS Domain</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statin Therapy at Discharge after Lower Extremity Bypass (LEB)</td>
<td>1519</td>
<td>257</td>
<td>Percentage of patients aged 18 years and older undergoing infra-inguinal lower extremity bypass who are prescribed a statin medication at discharge</td>
<td>Effective Clinical Care</td>
<td>Process</td>
</tr>
<tr>
<td>Rate of Open Repair of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications [Discharged to Home by Post-Operative Day #7]</td>
<td>N/A</td>
<td>258</td>
<td>Percent of patients undergoing open repair of small or moderate sized non-ruptured abdominal aortic aneurysms who do not experience a major complication (discharge to home no later than post-operative day #7)</td>
<td>Patient Safety</td>
<td>Outcome</td>
</tr>
<tr>
<td>Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications [Discharged to Home by Post-Operative Day #2]</td>
<td>N/A</td>
<td>259</td>
<td>Percent of patients undergoing endovascular repair of small or moderate non-ruptured abdominal aortic aneurysms (AAA) that do not experience a major complication (discharged to home no later than post-operative day #2)</td>
<td>Patient Safety</td>
<td>Outcome</td>
</tr>
<tr>
<td>Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications [Discharged to Home by Post-Operative Day #2]</td>
<td>N/A</td>
<td>260</td>
<td>Percent of asymptomatic patients undergoing CEA who are discharged to home no later than post-operative day #2</td>
<td>Patient Safety</td>
<td>Outcome</td>
</tr>
<tr>
<td>Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications [Discharged to Home by Post-Operative Day #2]</td>
<td>N/A</td>
<td>344</td>
<td>Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post-operative day #2</td>
<td>Effective Clinical Care</td>
<td>Outcome</td>
</tr>
<tr>
<td>Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS)</td>
<td>1543</td>
<td>345</td>
<td>Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital</td>
<td>Effective Clinical Care</td>
<td>Outcome</td>
</tr>
<tr>
<td>Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA)</td>
<td>1540</td>
<td>346</td>
<td>Percent of asymptomatic patients undergoing CEA who experience stroke or death following surgery while in the hospital</td>
<td>Effective Clinical Care</td>
<td>Outcome</td>
</tr>
<tr>
<td>Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital</td>
<td>1534</td>
<td>347</td>
<td>Percent of patients undergoing endovascular repair of small or moderate abdominal aortic aneurysms (AAA) who die while in the hospital</td>
<td>Patient Safety</td>
<td>Outcome</td>
</tr>
<tr>
<td>Rate of Open Repair of Ascending Abdominal Aortic Aneurysms [AAA] Where Patients Are Discharged Alive</td>
<td>1523</td>
<td>417</td>
<td>Percentage of patients undergoing open repair of abdominal aortic aneurysms (AAA) who are discharged alive.</td>
<td>Patient Safety</td>
<td>Outcome</td>
</tr>
<tr>
<td>Perioperative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy</td>
<td>0465</td>
<td>423</td>
<td>Percentage of patients undergoing carotid endarterectomy (CEA) who are taking an anti-platelet agent (aspirin or clopidogrel or equivalent such as aggrenox/tiglacor, etc.) within 48 hours prior to surgery and are prescribed this medication at hospital discharge following surgery.</td>
<td>Effective Clinical Care</td>
<td>Process</td>
</tr>
</tbody>
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# MIPS Reporting Submission Options

<table>
<thead>
<tr>
<th>MIPS Category</th>
<th>Available Reporting Mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality of Care</strong></td>
<td>Qualified Clinical Data Registry (QCDR)</td>
</tr>
<tr>
<td></td>
<td>Electronic Health Record</td>
</tr>
<tr>
<td></td>
<td>Claims Data</td>
</tr>
<tr>
<td></td>
<td>GPRO</td>
</tr>
<tr>
<td><strong>Resource Use</strong></td>
<td>Claims Data</td>
</tr>
<tr>
<td><strong>Advancing Care Information</strong></td>
<td>Attestations</td>
</tr>
<tr>
<td></td>
<td>QCDR</td>
</tr>
<tr>
<td></td>
<td>EHR</td>
</tr>
<tr>
<td><strong>Clinical Improvement Activities</strong></td>
<td>Attestation</td>
</tr>
<tr>
<td></td>
<td>QCDR</td>
</tr>
<tr>
<td></td>
<td>“Qualified Registry”</td>
</tr>
<tr>
<td></td>
<td>EHR</td>
</tr>
<tr>
<td></td>
<td>Claims Data</td>
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<tr>
<td></td>
<td>Claims Data</td>
</tr>
<tr>
<td>Resource Use Claims Data</td>
<td></td>
</tr>
<tr>
<td>Advancing Care Information Attestations</td>
<td>Qualified Clinical Data Registry (QCDR)</td>
</tr>
<tr>
<td></td>
<td>Vascular Quality Initiative (VQI) Database</td>
</tr>
<tr>
<td>Clinical Improvement Activities</td>
<td>Attestation</td>
</tr>
<tr>
<td></td>
<td>Qualified Clinical Data Registry (“Qualified Registry”)</td>
</tr>
<tr>
<td></td>
<td>EHR</td>
</tr>
<tr>
<td></td>
<td>Claims Data</td>
</tr>
</tbody>
</table>
Reporting Options

- **Group Practice**
  - **Qualified QCDR registry=VQI**
  - Web interface (for groups of 25+ only)
  - Direct EHR using CEHRT
  - CEHRT via data submission vendor
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS via CMS-certified survey vendor (for group practices of 2+)
How is VQI a part of the tools and solutions for SVS members

- Qualified Clinical Data Registry = VQI
- VQI/M2S, Inc. is an approved Qualified Registry vendor.
- Submission of Quality measures from 2017 to CMS for the 2019 requirement. In 2014 for this service, M2S charged a fee of $349 per participating physician at the time of submission.
Table II. Unique Characteristics of the Society for Vascular Surgery Vascular Quality Initiative

- Designed by physicians
- Risk-adjusted benchmarking
- One year follow-up
- Cases audited against claims data
- Center and physician-level reports
- Detailed clinical data
Quality

Practice Improvements

Advancing Care
Quality

Practice Improvements

Advancing Care

VQI®
Outcomes reported by the Vascular Quality Initiative and the National Surgical Quality Improvement Program are not comparable

Francesco A. Aiello, MD, Bing Shue, MD, Nisha Kini, MBBS, MPH, Amy Rosen, PhD, Louis Messina, MD, William Robinson, MD, Philimon Gona, PhD, and Andres Schanzer, MD, *Worcester, Mass*

**Objective:** The Vascular Quality Initiative (VQI) and National Surgical Quality Improvement Program (NSQIP) have emerged as the primary vascular surgery quality measurement tools with the purpose of evaluating perioperative outcomes and assessing hospital and physician quality. VQI uses self-reporting to capture all index vascular procedures during the inpatient period. NSQIP employs nurse abstractors to capture a sample of procedures and covers 30-day events. We hypothesize that patients undergoing lower extremity bypass (LEB) will exhibit high concordance for preoperative variables and low concordance for postoperative variables between these data sets.

**Methods:** All patients undergoing LEB for peripheral arterial disease at the University of Massachusetts captured in both VQI and NSQIP databases were reviewed (2007-2012). Concordance between categorical variables was assessed by kappa correlation coefficient. All postoperative variables were compared during equivalent inpatient stay. Events between discharge and 30 days postoperatively were tabulated with use of the NSQIP data set.

**Results:** We identified 240 patients undergoing LEB captured in both VQI and NSQIP. Comparison of this identical patient cohort between VQI and NSQIP revealed a moderate to strong agreement for most preoperative variables except for congestive heart failure (κ = 0.14) and hypertension (κ = 0.35), which showed poor agreement. Concordance for inpatient postoperative variables was high for mortality (κ = 1.0) and myocardial infarction (κ = 0.86) but moderate for pulmonary complications (κ = 0.57) and poor for unplanned return to the operating room (κ = 0.41), wound infection (κ = −0.01), and change in renal function (κ = −0.01). A majority of postoperative events (71%) occurred between discharge and 30 days postoperatively, with a significantly higher incidence of wound infections in the outpatient setting (4.2% vs 95.8%; *P < .0001*).

**Conclusions:** VQI and NSQIP demonstrate substantial concordance for most preoperative variables and poor concordance for most postoperative variables, even at identical collection periods. This discordance is a result of differences in data collection methods and variable definitions. On the basis of these findings, VQI and NSQIP data sets cannot be used to directly compare risk-adjusted patient outcomes between institutions. (J Vasc Surg 2014;**5**:1-8.)
Regional Quality Groups Enhance Effectiveness of Vascular Quality Initiative®.

Dunn J¹, Weaver FA, Woo K.

¹Division of Vascular Surgery and Endovascular Therapy, Keck School of Medicine, University of Southern California, Los Angeles, California, USA.

Abstract
The Vascular Quality Initiative (VQI)® is a national collaborative of regional quality groups that collect and analyze data to improve vascular health care. The Southern California Vascular Outcomes Improvement Collaborative (So Cal VOICe) is the regional quality group for southern California. Initial quality initiatives chosen by the So Cal VOICe are preoperative and discharge antiplatelet and statin therapy and vascular access guidance during percutaneous endovascular procedures. The objective of this study is to examine the influence of the regional quality group structure on the effectiveness of the So Cal VOICe. Data are entered by each institution into a cloud-based data collection and reporting system. So Cal VOICe data from January 2011 to July 2014 was analyzed in 6-month intervals. Preoperative statin and antiplatelet use increased from 58.87 to 71.81 per cent (P = 0.0082) and 60.8 to 78.38 per cent (P < 0.0001), respectively. Discharge statin and antiplatelet use increased from 69.09 to 80.37 per cent (P = 0.0037) and 80.47 to 88.11 per cent (P = 0.0148), respectively. Vascular access guidance improved from 32.89 to 76.23 per cent (P < 0.0001). Our results demonstrate the unique regional quality group structure of the VQI® improves compliance with selected process measures in the So Cal VOICe. Continued data collection will determine the impact of these process improvements on long-term patient outcomes.
Pathways for Different Vascular Surgery Practices for MIPS

- Private
- Academic
- Hospital employed
Private vascular surgery groups are in the best position because they control their costs, data, and patients.
What data will you report, VQI or NSQIP?
Report as Division of Vascular Surgery or part of Practice group?
Could that change whether you receive bonus or penalty?
Who decides how funds are distributed?
How to find out who is responsible and how to ensure quality reporting if you are a **hospital-employed physician**

- Most Vascular Surgeons unsure, waiting for SVS to tell them what to do.
- **Meet with your Chief Medical Office and Hospital CEO.**
  - Can I participate in VQI?
  - Will you pay the annual fee and hire an abstractor to manage my data?
  - Hire a consultant?
  - Who pays the penalty or receives the bonus?
Money in Merit Incentive Payment System (MIPS)

- Sliding Scale for bonus and penalty
- Congress allocated half billion for Special extra bonus (up to 25%) for high performers (2019 – 2024)
- 2019 - +/- 4%, 2020 - +/- 5%, 2021 - +/- 7%, 2022 and beyond - +/- 9%
- 4 Vascular Surgeons at TGH

- 4% x 1,750,000 = $70,000 bonus for our group
- 25% x 1,750,000 = $437,5000

Only 51% of physicians reporting currently. Expect only 28% to report full calendar year in 2017
At the national level, SVS has partnered with ACS to have Brandeis to develop APMs for EVAR, Carotid, PVD

Tell your payers that you will have APMs based on clinical proven guidelines for the care of Vascular patients. You can take care of all of the needs for:

- PVD (cardiology already has APM proposed)
- Carotid disease
- AAA
- Diabetic foot (have guidelines with Podiatry)
The role of clinical practice guidelines and how SVS guidelines will help when APMs arrive

- 2011ASA/ACCF/AHA/AANN/AANS/ACR/ASNR/CNS/SAIP/SCAI/SIR/SNIS/SVM/SVS Guideline on the Management of Patients With Extracranial Carotid and Vertebral Artery Disease: Executive Summary
- Guidelines along with claims data will allow Vascular Surgeons to develop Alternative Payment Models (APMs) for each vascular disease.
- CMS especially likes guidelines that cross multiple specialties
2017 Quality Payment Program (MACRA)

CMS Listens: Physicians to Pick their Own Pace
“Plans for the Quality Payment Program in 2017: Pick Your Pace”

1st Option: Test the Quality Payment Program.
Submit some data to the Quality Payment Program, including data from after January 1, 2017, you will avoid a negative payment adjustment. This first option is designed to ensure that your system is working and that you are prepared for broader participation in 2018 and 2019 as you learn more.

2nd Option: Participate for part of the calendar year.
You may choose to submit Quality Payment Program information for a reduced number of days. This means your first performance period could begin later than January 1, 2017 and your practice could still qualify for a small positive payment adjustment.

3rd Option: Submit Quality Payment Program information for a full calendar you could qualify for a modest positive payment adjustment.

4th Option: Participate in an Advanced Alternative Payment Model in 2017
Then you would qualify for a 5 percent incentive payment in 2019.
Similar Sized Society PACs – 2013-14

American Assn of Neurological Surgeons $414,402

Society For Radiation Oncology $323,098

SVS $210,100
Mission of SVS Quality Performance and Measures Committee

- Improve the care of vascular patients
- More efficient care
- Know our results
- Make the practice of Vascular Surgery for all providers more enjoyable and rewarding
Vascular Surgeons are passionate and determined that patients with vascular disease should have QUALITY CARE.
“Say .... what's a mountain goat doing way up here in a cloud bank?”
MACRA - Impact to a Vascular Surgeon’s Practice: Tools for SVS Members

BRAD JOHNSON, MD
PROFESSOR OF SURGERY
DIVISION OF VASCULAR SURGERY