

MACRA and Gorillas

BRAD JOHNSON, MD

PROFESSOR OF SURGERY



Financial Disclosure

- ▶ I have nothing to disclose









Mission of SVS Quality Performance and Measures Committee

- ▶ SVS Member education- Webinars and SVS articles
- ▶ Coordination of future measure development with VQI
- ▶ Respond to CMS proposals
- ▶ Prepare for the future-
 - Episode-Based Cost Measure Development for the Quality Payment Program
 - APMs

Agenda

- ▶ SVS response to 2018 CMS Proposal
- ▶ Future?
- ▶ Questions and discussion

SVS Proposed Changes for 2018

- ▶ We believe that for those newly-enrolled eligible clinicians (vascular surgery graduates) who bill their first Medicare patient after September 1 of a given year, they should be exempt from MIPS reporting for the entire next calendar year.

Academic Practices

The SVS believes this is a fundamental and very important element of the Quality Payment Program under MACRA and that a method for sub-group reporting must be created such that specialty-specific sub-groups under a larger TIN can be identified and allowed to report specialty-relevant MIPS measures. The process that CMS is proposing for the virtual groups in which individual physicians of the same specialty join together as a subgroup for the purposes of MIPS reporting is important if the MIPS program is to be relevant for specialists

Division of Vascular Surgery can report separately from Practice Plan

ie. Influenza immunization

CMS BLOG

<http://blog.cms.gov/2016/09/08/QualityPaymentProgram-PickYourPace>

September 8, 2016

By Andy Slavitt, Acting Administrator of CMS

“Plans for the Quality Payment Program in 2017: Pick Your Pace”

DON'T PARTICIPATE

If you don't participate, you will receive a 4% negative payment adjustment

-
\$

SUBMIT SOMETHING

- One Measure
- One Activity

Avoid a negative payment

SUBMIT A PARTIAL YEAR

- Submit 90 days of 2017 data to Medicare

You may earn a neutral or small positive payment adjustment

SUBMIT A FULL YEAR

You may earn a moderate payment adjustment

+
\$

FINANCIAL IMPACT

Pick Your Pace

- ▶ CMS provide “Pick Your Pace” options in 2018 similar to what the agency did for MIPS in 2017 that will help virtual groups avoid penalties.

Reporting Burden

- ▶ Reporting claims-based measures for a continuous 12-month period will be a large, additional burden for a practice's administrative staff. Also, private practice specialty physicians, like SVS members, are more likely to see patients at multiple facilities, so capturing the data needed to report 12-months of a quality measure 50 percent of the time will be very challenging. Even reporting to a QCDR on measures for a 12-month period is very labor intensive and costly to any size practice. SVS members who participate in VQI have needed to hire data managers to collect and transmit all their data to the VQI, of which there are several registries for various vascular surgery procedures and conditions.
- ▶ Therefore, the SVS urges CMS to finalize a reporting period for all categories under MIPS to be 90-continuous days in all future reporting years.

Reporting Burden

- ▶ SVS supports CMS' proposal to allow data for each of the MIPS categories to be submitted via **multiple data submission mechanisms**. This will allow eligible clinicians to select the mechanism that best fits their practice's capabilities and resources. However, we are concerned that CMS is also considering making it part of the validation process for the review of whether six measures are available for reporting by a given specialty in all mechanisms.
- ▶ To **mandate** that an eligible clinician take on the added expense of **submitting measures via two different mechanisms** is not appropriate nor does it help eligible clinician practices, particularly those in private practice, to be able to cover the costs of MIPS participation. The SVS wants to ensure that this flexibility CMS is proposing is truly that, flexibility, to help those that are struggling to participate in the QPP and not a barrier created as an unintended mandate.

- 
- ▶ Therefore, CMS needs to delay this proposal regarding topped out measures to future rulemaking. Over the next 12-months, CMS needs to work with the medical societies that have some of the older measures to study the durability of the quality improvement they have facilitated prior to a proposal regarding removing measures. **Don't delete Measures**
 - ▶ The SVS recommends that CMS perform research to see if evidence has been published regarding the number of clinicians needed regarding the performance of a clinical improvement activity to make a difference in practice or patient outcomes. In the absence of published literature, CMS should perform research to establish this critical evidence. **Help us with outcomes research**

QCDRs are as important as immunizations

- ▶ However, since immunization reporting holds little relevance for specialties dealing primarily with geriatric populations, we urge CMS to provide 10 percentage points for public health registry reporting, or 10 percentage points for clinical data registry reporting. Reporting to both types of registries is of equal importance to improve the quality of care and public health of our population.
- ▶ **VQI is as important as immunizations.**

Sick patients

- ▶ We believe bonus points should be awarded in recognition of physicians who treat the sickest patients with the most complex diseases, those are unfortunately but often accompanied by devastating complications. For vascular surgeons, the relevant categories of patient would include those with severe peripheral vascular disease causing critical limb ischemia, and those patients with acute, life-threatening aortic pathology.
- ▶ . Therefore, we propose that CMS establish a process for when a quality measure does not have enough individuals reporting the measure for the purposes of benchmarking, that CMS work with the medical society which developed the measure or the QCDR that is collecting data on the measure in order to establish the needed benchmarks.
- ▶ **BONUS points for sick complex Vascular pts**





Future?



UNDER THE MACRASCO

Cost measurement and payment implications Payment Program

Yazan Duwayri, MD,^a Brad Johnson, MD,^b Jill Rathbun, MHSA,^c and Karen
Tampa, Fla; Chicago, Ill; and Los Angeles, Calif

Healthcare cost disparities created by the traditional
for-service payment model have been the primary
leading to the development of the Quality Pay

be measured for
vascular surgical
repair and conditi

Cost Category will increase to 30% by 2021

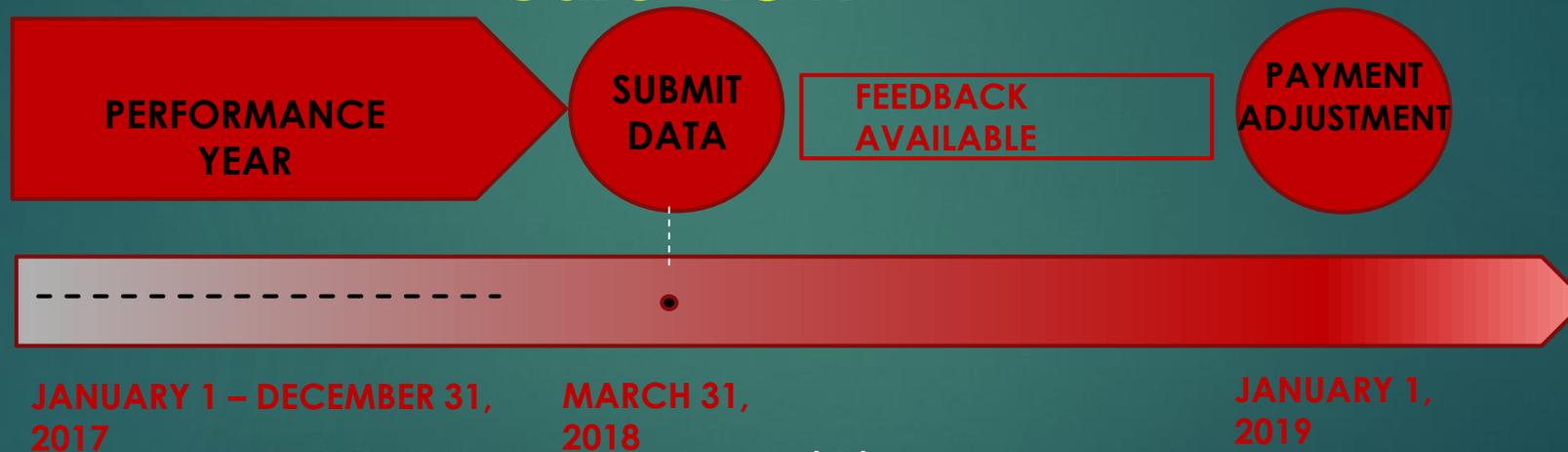
- ▶ CMS developing **Episode-based resource use measures**
- ▶ CMS encouraging **APM** development to promote quality and control cost

Cost Data

- ▶ At the very least, CMS must produce quarterly reports on a physician's resource use/cost information compared to other MIPS Eligible Professionals since the information is based on claims' submission. CMS also needs to devote the necessary resources, including dedicated CMS staff, to help physicians and administrators interpret the feedback reports.
- ▶ **Understandable feedback more often on costs**

MIPS Proposed Timeline for 2019 Payment

**Why I should
care NOW**



*What you do today, will impact your payment
in 2019!*

VQI Participants are the Silverbacks



Deming

85/15 rule- Your system is responsible for 85% of your problems and 15% is due to your personnel

VQI is a good system that provides value and controls cost



Preparing Your Practice for Medicare's New Quality Payment Program: Quality Reporting Made Easy

Q&A Town Hall Webinars
Learn More About Medicare Reimbursement,
Effect on Practices

Times are 1 p.m. Eastern Time, Tuesday, Sept.
12, and 7 p.m. Eastern Time, Tuesday, Sept.
19. Moderators are Jill Rathbun and Drs.
Michael Stoner and Caitlin Hicks of SVS'
Quality and Performance Measures
Committee

Does everybody get the "SVS
Pulse" email?

CMS Quality Program Website

<https://qpp.cms.gov/about/resource-library>



Regional Society Meetings

Similar Sized Society PACs – 2013-14

American Assn of Neurological Surgeons	\$414,402
Society For Radiation Oncology	\$323,098
SVS	\$210,100



Questions?

- ▶ How many people are participating in MIPS?
- ▶ Entire year?
- ▶ Using VQI to report?
- ▶ Any idea how much bonus/penalty may be? USF Academic practice plan estimates \$2 million bonus



Sanity Surgeons



Karen Woo, MD UCLA



Yaz Duwayri, MD Emory Uni.





Jack Cronenwett, MD

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

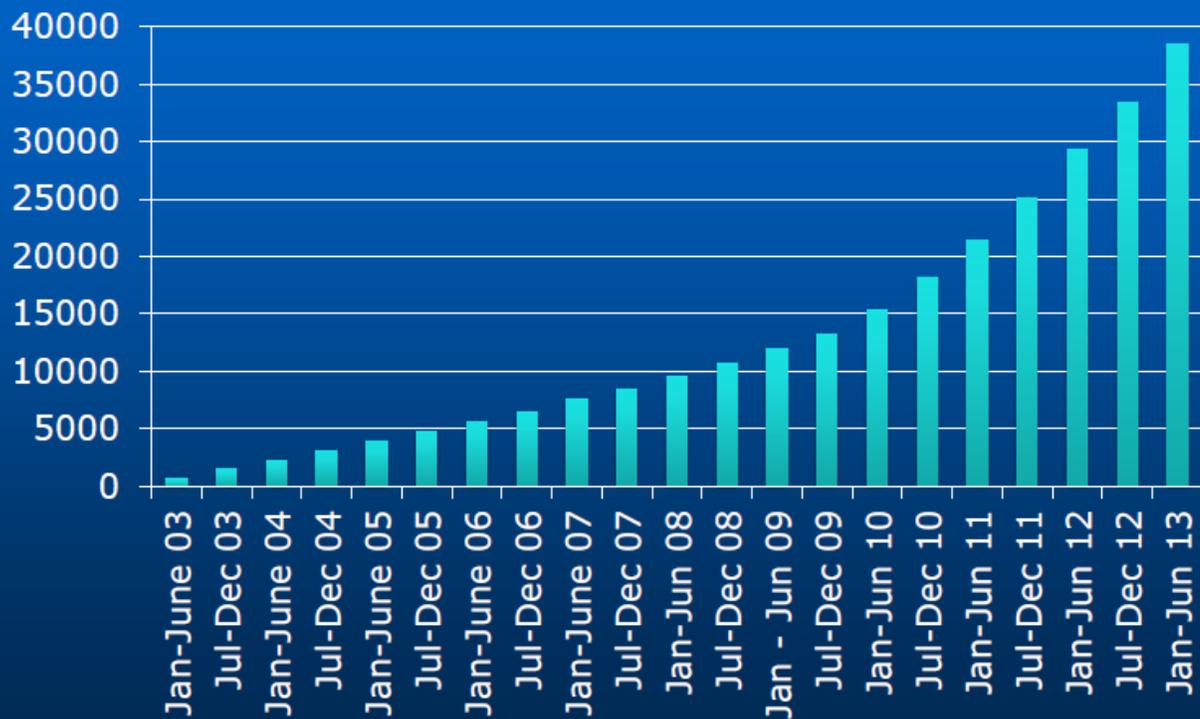
30 Participating Hospitals

15 Community - 15 Academic



>38,000 Procedures Reported

CEA, CAS, oAAA, EVAR, LEB, PVI, TEVAR, Access



United States Air Force Academy and Duke University Medical School.
Harvard Medical School-Vascular Surgery Fellowship
Mayo Clinic -founding member of the Mayo Vascular Center and
Associate Dean for Faculty Affairs.



Alaskan Kongakut River Rat

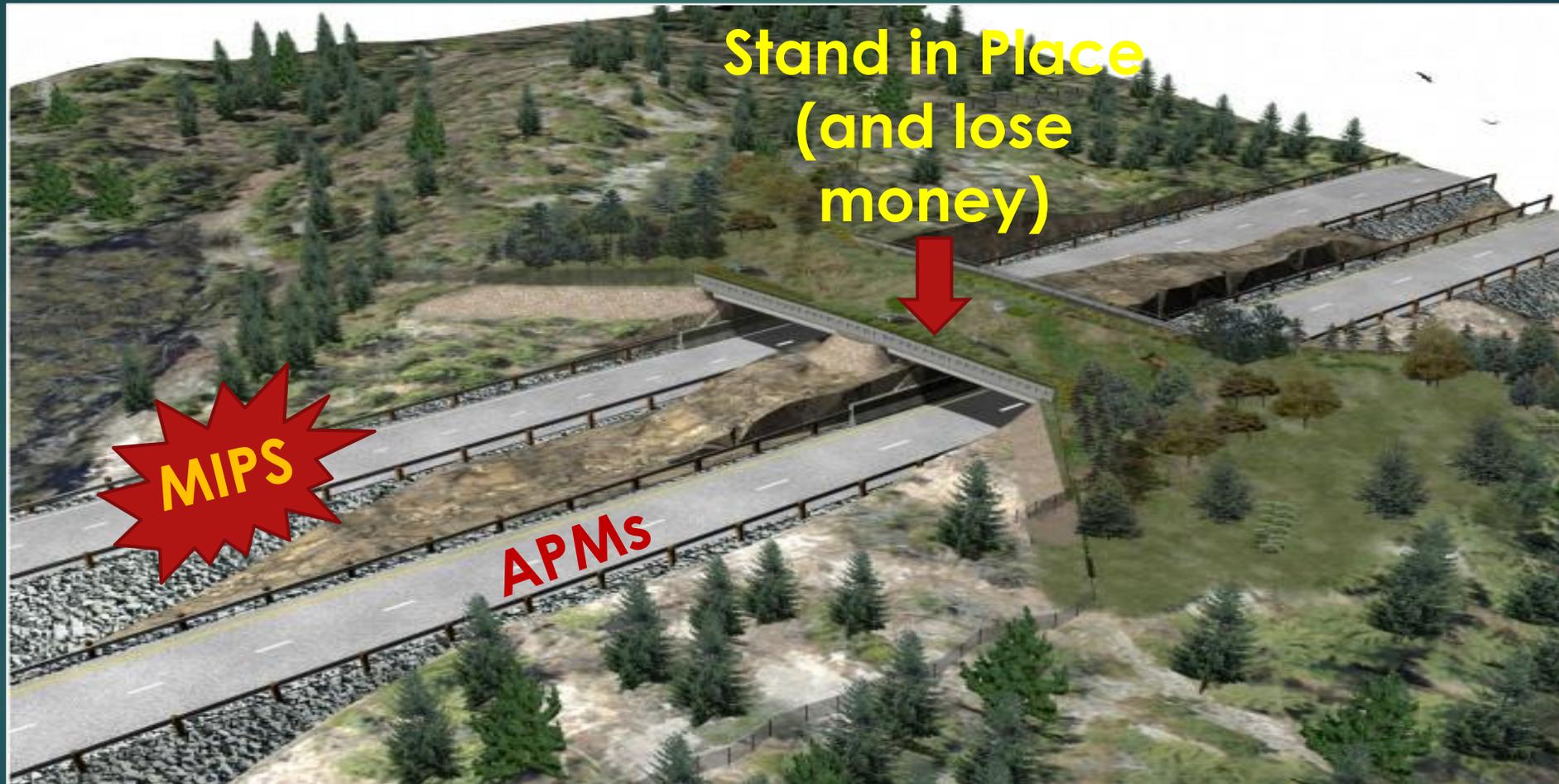


MACRA- Impact on a Vascular Surgeon's Sanity

Working to Prepare for MACRA



Starting in 2017, physicians will have to choose



Impact to a Vascular Surgeon's Practice: Tools for SVS Members

- ▶ MIPS-overview and update
- ▶ MIPS- impact on private, academic, and hospital employed vascular surgeons
- ▶ QPMC working with VQI on future measure development
- ▶ ?what will MACRA look like in 2025

How are SVS members meeting reporting requirements?



Vascular Quality Initiative®

vs.



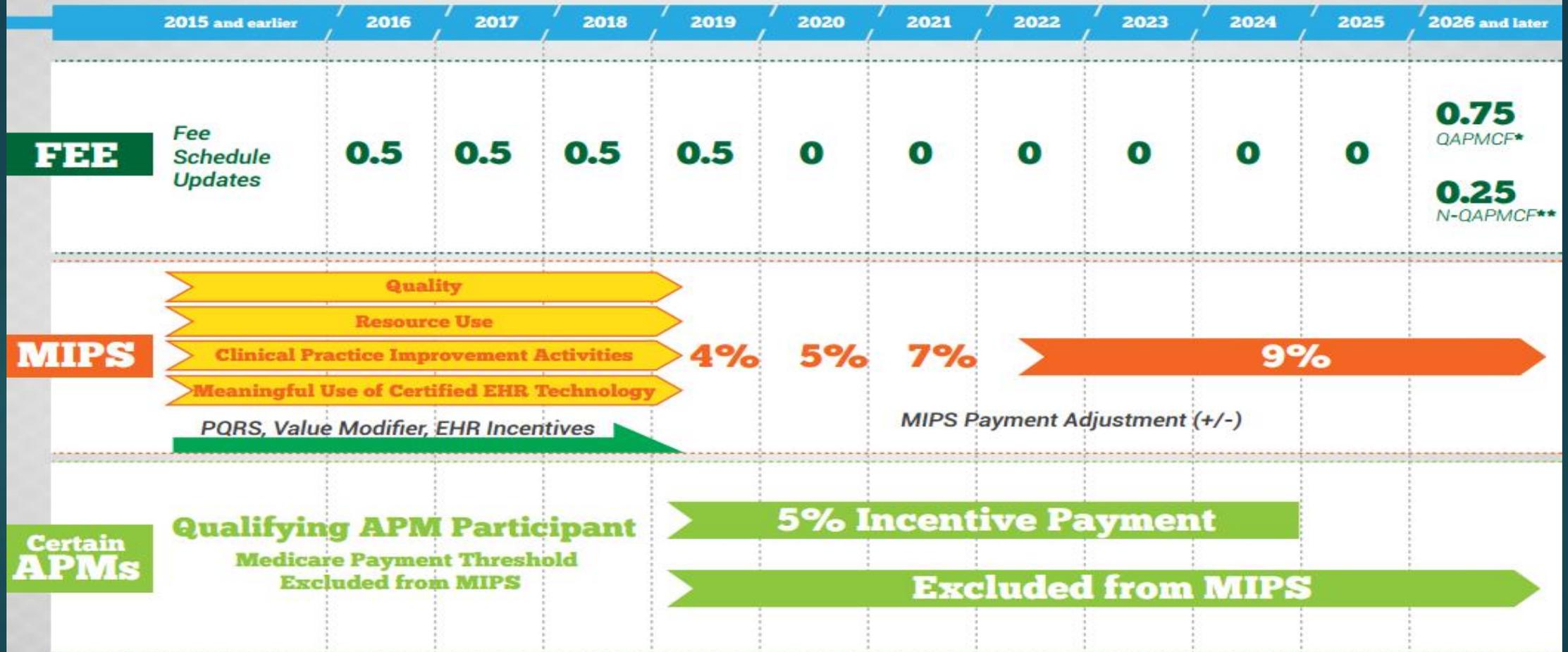
Deloitte.



“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



*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:



Are newly enrolled in Medicare;



Have less than or equal to \$10,000 in Medicare charges and less than or equal to 100 Medicare patients; or



Are significantly participating in an Advanced Alternative Payment Model (APM).

Quality (replaces PQRS)	60% of the total score in year 1 (Decreases to 50% in 2018; 30% in 2019 and thereafter)
Advancing Care Information (ACI) (replaces EHR Meaningful Use)	25% of the total score in year 1
Improvement Activities (new)	15% of the total score in year 1
Cost (based on claims data)	0% of the total score in year 1 (Increases to 10% in 2018; 30% in 2019 and thereafter)



Quality 60%

- ▶ *Clinicians* choose six measures to report to CMS that best reflect their practice.
- ▶ Participating in VQI meets the Quality requirement

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

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- ▶ 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.

15% Clinical Practice Improvement Activities:

- ▶ 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?*

0% 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.

0% 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?*

Ideas for MIPS using VQI Data

- ▶ Identify Quality Improvement Projects for your Center
- ▶ Request National Blinded Data Sets to research specific questions
- ▶ Support Certifications
- ▶ Utilize data to understand practice variation using different devices or techniques
- ▶ VQI is a specialty registry



SVS Developed Quality Measures

Measure Title	NQF	PQRS	Measure Description	NQS Domain	Measure Type
Statin Therapy at Discharge after Lower Extremity Bypass (LEB)	1519	257	Percentage of patients aged 18 years and older undergoing infra-inguinal lower extremity bypass who are prescribed a statin medication at discharge	Effective Clinical Care	Process
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)	N/A	258	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)	Patient Safety	Outcome
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)	N/A	259	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)	Patient Safety	Outcome
Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2)	N/A	260	Percent of asymptomatic patients undergoing CEA who are discharged to home no later than post-operative day #2	Patient Safety	Outcome
Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)	N/A	344	Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post-operative day #2	Effective Clinical Care	Outcome
Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS)	1543	345	Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital	Effective Clinical Care	Outcome
Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA)	1540	346	Percent of asymptomatic patients undergoing CEA who experience stroke or death following surgery while in the hospital	Effective Clinical Care	Outcome
Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital	1534	347	Percent of patients undergoing endovascular repair of small or moderate abdominal aortic aneurysms (AAA) who die while in the hospital	Patient Safety	Outcome
Rate of Open Repair of Ascending Abdominal Aortic Aneurysms (AAA) Where Patients Are Discharged Alive	1523	417	Percentage of patients undergoing open repair of abdominal aortic aneurysms (AAA) who are discharged alive.	Patient Safety	Outcome
Perioperative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy	0465	423	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.	Effective Clinical Care	Process

MIPS Reporting Submission Options

MIPS Category	Available Reporting Mechanisms
<i>Quality of Care</i>	Qualified Clinical Data Registry (QCDR) Electronic Health Record Claims Data GPRO
<i>Resource Use</i>	Claims Data
<i>Advancing Care Information</i>	Attestations QCDR EHR
<i>Clinical Improvement Activities</i>	Attestation QCDR “Qualified Registry” EHR Claims Data

MIPS Reporting Submission Options

MIPS Category	Available Reporting Mechanisms
<i>Quality of Care</i>	Qualified Clinical Data Registry (QCDR) Electronic Health Record Claims Data
<i>Resource Use</i>	Qualified Clinical Data Registry (QCDR)= Vascular Quality Initiative (VQI) Database
<i>Advanced Clinical Practice</i>	QCDR EHR
<i>Clinical Improvement Activities</i>	Attestation QCDR “Qualified Registry” EHR Claims Data

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+)

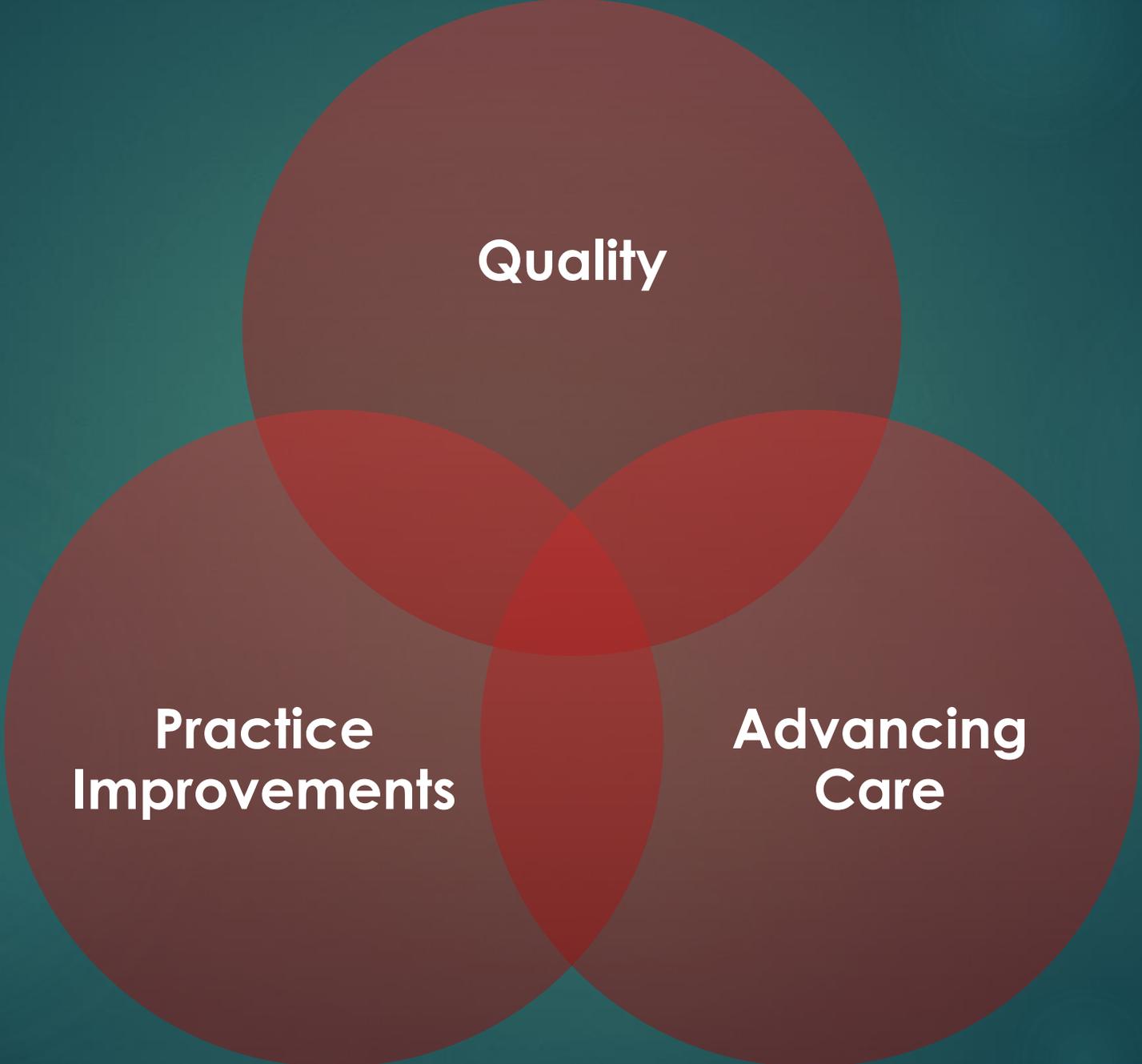
How is VQI a part of the tools and solutions for SVS members

- ▶ 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

- Organized as a Patient Safety Organization to permit collection of patient-identified information but protect benchmarked comparisons from legal discovery or use in disciplinary actions
 - Organized as a distributed network of regional quality groups to facilitate local translation of registry data into practice change while using the power of a national registry
 - Includes all physician specialties that perform vascular procedures
 - Collects detailed clinical data specific to each vascular procedure type for all commonly performed open and endovascular procedures
 - Provides risk-adjusted benchmarking and quality measure reports for each procedure
 - Permits international participation for benchmarking within and between countries
 - Allows data entry at the time and point of care to distribute and reduce data entry costs
 - Collects 1-year or longer follow-up events during physician office visits
 - Uses patient-identifiers to match with other data sets, such as the Social Security Death Index or Medicare claims, to retrieve downstream events that occur even after 1-year follow-up
 - Performs audits to ensure consecutive procedure entry using physician and hospital billing data
 - Uses a single-vendor, low cost, Web-based system for data entry and real-time reporting
 - Meets maintenance of board certification requirements related to quality improvement participation
-

- ▶ **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**



A Venn diagram with three overlapping circles. The top circle is labeled 'Quality', the bottom-left circle is labeled 'Practice Improvements', and the bottom-right circle is labeled 'Advancing Care'. In the center, where all three circles overlap, is a white square containing the text 'VQI®'. The background is a dark teal color with a red vertical bar in the top right corner.

Quality

VQI®

**Practice
Improvements**

**Advancing
Care**

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 κ 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 ($\kappa = 0.14$) and hypertension ($\kappa = 0.35$), which showed poor agreement. Concordance for inpatient postoperative variables was high for mortality ($\kappa = 1.0$) and myocardial infarction ($\kappa = 0.86$) but moderate for pulmonary complications ($\kappa = 0.57$) and poor for unplanned return to the operating room ($\kappa = 0.41$), wound infection ($\kappa = -0.01$), and change in renal function ($\kappa = -0.01$). 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;■:1-8.)

Journal of Vascular Surgery

, September 2016, Pages 629–637

Vascular Quality Initiative and National Surgical Quality Improvement Program registries capture different populations and outcomes in open infrainguinal bypass

Presented at the Fortieth Annual Meeting of the Southern Association for Vascular Surgery, Cancun, Mexico, January 20-23, 2016.

Lily E. Johnston, MD, MPH^a,

William P. Robinson, MD^a,

Margaret C. Tracci, MD, JD^a,

John A. Kern, MD^a, b,

Kenneth J. Cherry, MD^a,

Irving L. Kron, MD^a, b,

Gilbert R. Upchurch Jr., MD, FACS^a

Clinical Practice Improvement Activities:

Regional Quality Groups Enhance Effectiveness of Vascular Quality Initiative®.

[Dunn J](#)¹, [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**

Implementation: Private practice



Private vascular surgery groups in the best position for they control their costs, data, and patients.

Implementation: Academic practice



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?

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

Reality at USF

- ▶ Practice Leaders decided to fully participate for the entire year and report as a group
- ▶ Included one vascular measure. May include more next year since they like VQI
- ▶ USF Practice Plan estimates 2 million bonus or loss
- ▶ **We are playing the game!**

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?

The role of clinical practice guidelines and how SVS guidelines will help when APMs arrive

- ▶ 2011 ASA/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

Journal of Vascular Surgery Articles

UNDER THE MACRASCOPE

The vascular surgeon's roadmap to success in the Quality Payment Program

Yazan Duwayri, MD,^a Brad Johnson, MD,^b Jill Rathbun, MHSA,^c and Karen Woo, MD,^d Atlanta, Ga; Tampa, Fla; Chicago, Ill; and Los Angeles, Calif

MIPS: Clinical Practice Improvement Activities

Rocco G. Ciocca, MD,¹ Brad Johnson MD², Jill Rathbun, MHSA,³ Karen Woo MD,

Medicare's new quality payment program for physicians: An overview

Karen Woo, MD,^a Jill Rathbun, MD,^b and Brad Johnson, MD,^c Los Angeles, Calif; Chicago, Ill; and Tampa, Fla

Utilizing registries to meet Medicare reimbursement requirements

Ash Mansour, Brad Johnson, Jill Rathbun, Karen Woo

Vascular Quality Initiative®

PSO National QI Project Committee Process

SVS PSO

- Identify high performing centers
- **Provide input to/from regional meetings**
- Develop educational resources
- Develop COPI and Physician Reports
- **Align with MIPS/MACRA**
- Track successes



April 24, 2017

Acumen, LLC

On behalf of the Centers for Medicare & Medicaid Services

Re: Comments on the draft list of episodes and the associated trigger codes as well as the Episode-Based Cost Measures for the Quality Payment Program Report

Dear Staff for Acumen, LLC:

The Society for Vascular Surgery (SVS), a professional medical society composed of 5,400 specialty-trained vascular surgeons and other medical professionals who are dedicated to the prevention and cure of vascular disease, is very concerned regarding the initial draft list of episodes and the associated triggers for a patient to be attributed to said episodes and their lack of specificity and clinical homogeneity. Our comments below detail these concerns.

Acumen needs to agree to the SVS offer to convene our leaders and working directly with us starting with a multi-day face to face meeting SVS is also nominating several individuals for the Acumen, LLC Clinical Subcommittees for the Cardiovascular Disease Management, and Peripheral Vascular Disease Management separately and we would encourage Acumen to select all the SVS nominees.

Sincerely,

Ronald Fairman, MD

President

Society for Vascular Surgery

Sean Roddy, MD

Chair, Policy and Advocacy Council

Society for Vascular Surgery

Michael Dalsing, MD

Chair, Government Relations Committee

Society for Vascular Surgery

Brad Johnson, MD

Chair, Quality and Performance Measures Committee

Society for Vascular Surgery

Matthew Sideman, MD

Chair, Coding and Reimbursement Committee

Response from Acumen

MACRA Episode-Based Cost Measures CLINICAL SUBCOMMITTEE

- ▶ **PVI-** episode groups: Dialysis Access, Inferior Vena Cava Filter Placement, Lower Extremity Peripheral Vascular Disease Treatment, Procedure for Carotid Stenosis

Vascular Surgery, Cardiology, General Surgery, Interventional Cardiology, Interventional Radiology, Diagnostic Radiology, Anesthesiology, Geriatric Medicine, Family Medicine, Internal Medicine, Physician Assistant, Nurse Practitioner, Certified Registered Nurse Anesthetist, Peripheral Vascular Disease, Preventive Medicine, Licensed Clinical Social Worker, Clinical Nurse Specialist

SVS- Myself and Karen Woo- June 13th meeting in Wash. DC

Cardiovascular Disease Management

- episode groups: Chest Pain, Coronary Artery Bypass Graft (CABG), Coronary Thrombectomy, Heart Failure & Shock, Implantable Cardiac Defibrillator (ICD) Implantation, Left Heart Catheterization, Mitral Valve Procedure, Pacemaker Implantation, Percutaneous Coronary Intervention (PCI), Right Heart Catheterization, Supraventricular Tachycardia (SVT) Ablation, Syncope & Collapse, **Thoracic Aortic Aneurysm Repair**, Ventricular Tachycardia (VT) Ablation

- Cardiology, Cardiac Electrophysiology, Cardiac Surgery, Interventional Cardiology, Diagnostic Radiology, Thoracic Surgery, Anesthesiology, Vascular Surgery, Critical Care (Intensivist), Intensive Cardiac Rehabilitation, Emergency Medicine, Geriatric Medicine, Internal Medicine, Family Medicine, Physician Assistant, Nurse Practitioner, Certified Registered Nurse Anesthetist, Licensed Clinical Social Worker, Clinical Nurse Specialist

SVS-Matthew Sideman and me- June 15th

SVS and VQI: Preparing for APMs

- ▶ At the national level, SVS has partnered with ACS to have Brandeis to develop APMs for EVAR, Carotid, PVD. **Now have our own committee working on APMs**
- ▶ 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)

SVS APM Ad hoc Committee

Chair – Yazan Duwayri, MD,

QPMC

Robert Larson, MD
Patrick Ryan, MD
Karen Woo, MD

Government Relations

Matthew Mell, MD
Reagan Quan, MD
Megan Tracci, MD
Willaim Shutze, MD

Coding

Francesco Aiello, MD
Matthew Sideman, MD
Bob Zwolak, MD

Clinical Practice

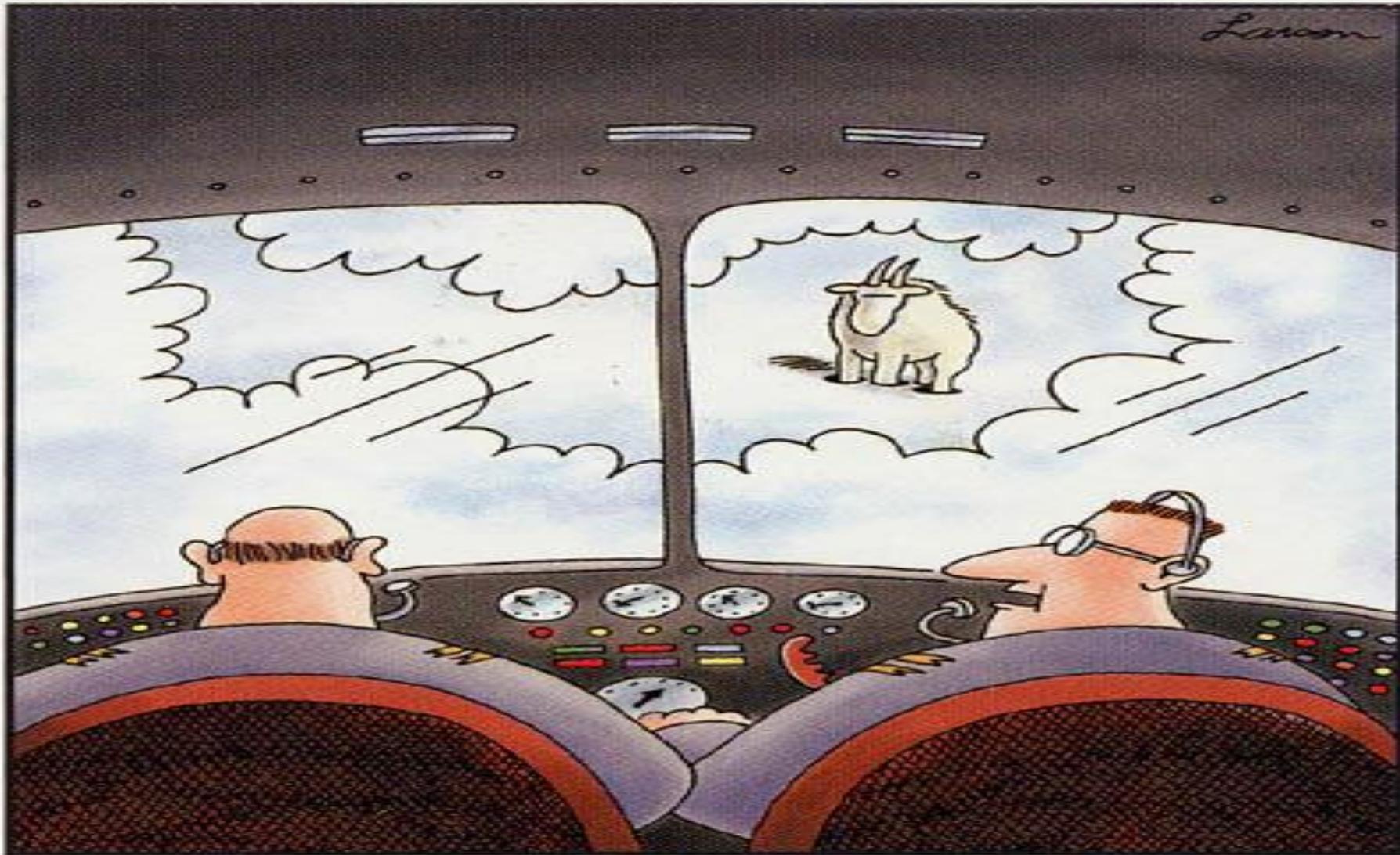
Mark Davies, MD
Natalia Glebova, MD
Ying Wei Lum, MD

Community Practice

John Adams, MD
Daniel McDevitt, MD

Committee's Goals

- Develop Vascular APMS for SVS members to use:
 - in contracting with private insurance companies
 - in working with Medicare under the new Quality Payment Program (QPP).
- Provide SVS members with the resources needed to be successful under QPP and to ensure access to high quality care for their patients.
- Explore how the use of the Vascular Quality Initiative (VQI) can be incorporated into the model to meet both the quality performance and practice capability requirements

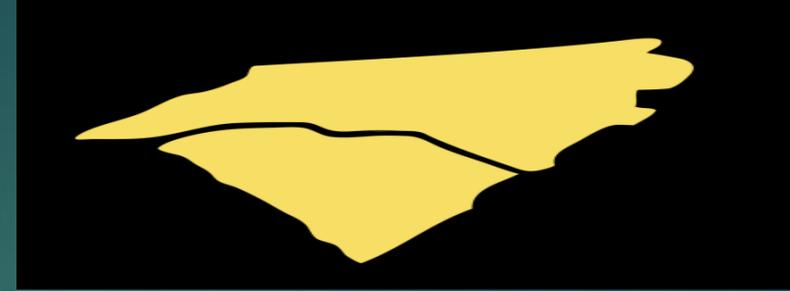


"Say ... what's a mountain goat doing way up here in a cloud bank?"

Vascular Surgeons are passionate
and determined that patients with
vascular disease should have
QUALITY CARE.

SVS





Carolina's Vascular Quality
Group. May 5, 2017

MACRA for Dummy Vascular Surgeon's Sanity

BRAD JOHNSON, MD

PROFESSOR OF SURGERY

DIVISION OF VASCULAR SURGERY

