TNAFP 2022 Annual Practice Enhancement Seminar

Understanding the Business of Medicine

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Disclaimer/Conflicts

- E. G. "Nick" Ulmer, Jr., MD CPC is the owner of the entire content of this presentation. Any questions related to interpretation of the coding guidelines discussed herein should be directed to Dr. Ulmer at:
  - NUlmer@ProtimeLLC.com or
  - 864-684-4248 (cell/text)
- The ultimate authority on the interpretation of CMS guidance rests with your Medicare Administrative Contractor (MAC).
  - Search www.cms.gov and "Who are the MACs" to locate yours.
- Spartanburg Regional Healthcare System is in no way related to the educational content of this presentation.

Objectives

- Know the global history of the Medicare Program and understand the parts (A, B, C, and D) that make it up
- Define and understand the 2022 changes to the conversion factor
- Know the out-of-pocket costs associated with the Medicare Beneficiary in 2022 and shared savings and how cost of care play into payments
- Know the various business models in practice to include ACOs, Medicare Advantage, shared savings, and risk.

Before “business”, we need “background”…

- America’s health care system is no stranger to politics
- In WWII (09/01/1939 – 09/02/1945), health care policy in America began morphing
  - Military (and those working for the government in war efforts and beyond) needed help with healthcare costs/services – meet their needs due to their sacrifice
  - 1940’s employer-sponsored healthcare followed suit. Retain and attract the best.
- 1942, penicillin was first used. Push to expand availability (military need) and having it covered in insurance was a natural
- Title XIX of the Social Security Act, Medicaid and Medicare enacted (1965)
  - Medicare: the old, disabled Medicaid: the poor
- The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 requires hospitals to screen and stabilize (treat) every patient who comes to the hospital ED seeking care, regardless of the patient’s ability to pay and regardless of what it costs the hospital to provide the care.
- 2006, Part D (drug coverage) was added as an option to Medicare
- 2010, the Affordable Care Act with expanded coverage with prevention being added as a basic coverage option

The Problem

- What was Medicare set up to do?
  - Recruit/retain workers (WWII wage controls) in industry
  - Expand healthcare coverage and provide a benefit to beneficiaries (65 until death)
  - Assist in healthcare expense - in some cases (VA) "spare no expense" to meet need
  - Cover the uninsured and low income (Medicaid)
  - Treat all in emergency conditions regardless of ability to pay (EMTALA)
- What was Medicare NOT set up to do?
  - Encourage healthy behaviors
  - Manage chronic disease
  - Contain costs
  - Hold people accountable

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America's expectations ….

1. *Give me the best health care in the world*
2. *Send the bill to someone else*
3. *Don't bother me about my behaviors*

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As providers, we need to better understand the business and align that with needed quality initiatives outside of the politics

The Business of Medicine: Insurance/Plan Types

Medicaid

- State-by-state rules
- The nation's public health insurance program for people with low income. The vast majority of Medicaid enrollees lack access to other affordable health insurance.
- Covers critical role for certain populations like deliveries, special care needs in children, nonelderly adults with disabilities, and more than six in ten nursing home residents.
- Reimbursements are usually below what most physicians need to sustain an economically viable practice. So access for these patient types is often limited

Rudowitz, et. Al.; 10 Things to Know about Medicaid: Setting the Facts Straight; Kaiser Family Foundation. Accessed 01/2021

Commercial

- Employer funded or a blend of employer/employee funded
- All over the board re: premiums, co-pays, benefits (employer sets)
  - More premium paid per month (employer or employee), usually better benefits (less out of pocket co-insurance, deductible) and more covered services (pharmacy benefits)
  - High deductible health plans are options
    - More economic responsibility on patient/employee up front before insurance starts to pay

Medicare Program[1]

- Health insurance set up for people (1965)
  - 65 yoa and older (ie, those who "age in" to program)
  - People under 65 with certain disabilities
  - People of all ages with end-stage renal disease (people with dialysis or kidney transplants) and Amyotrophic Lateral Sclerosis (ALS)
- Funded by payroll tax (employee payroll deductions and employer-based taxes), premiums/surtaxes from beneficiaries, and general revenue

Medicare Parts[1]

- Has different "parts"
  - Part A: covers hospital inpatient care ("formally admitted"), skilled nursing care (after 3d qualifying stay*), hospice care and some home health care
  - Part B: covers outpatient medical care like physician and lab fees, outpatient diagnostic tests, durable medical supplies, same-day surgery procedures, observation care in a hospital setting, ED services, some home health care. Outpatient physician service costs vary based on whether a physician "participates" (Par vs non-Par fee schedule)
- Coverage for part A is based on amount paid thru payroll taxes during employment. No premium if paid enough, with option to purchase if not (99% do not have a premium since > 40 quarters of Medicare-covered employment). Part A can be purchased
- Hospitals get paid differently for the Part A and Part B

Medicare Part A and B[2]

- CMS pays most **acute care facilities for inpatient care** under the Inpatient Prospective Payment System (IPPS) in the **Part A** Medicare program
- Payment is set based on the conditions cared for, the procedures performed, and the severity of illnesses encountered during the stay. These are expressed through the physician's written word and payment is assigned to a Medicare Severity-Diagnosis Related Group (MS-DRG). One fee is paid for all care delivered by the hospital for that inpatient stay.
  - Assigned regionally, weighted for cost of services delivered

Medicare Part A and B

- For hospital care, the physician must determine the "status" of the patient and assign an order to have the patient placed in the hospital. Must be formally admitted as an "inpatient" (Part A) or placed in an "outpatient observation" (Part B) *status* or *level of care*.
  - Clinical decision by provider. Two Midnight Rule → Inpatient
  - The hospital will be paid differently based on IP or OBS status, the physician pay is about the same
  - The patient financial responsibility is different based on the status of the stay
  - Provider documentation must indicate the need ("medical necessity") of the care to be delivered to justify payment

Part B: Outpatient Billing of Medicare

- The Outpatient Prospective Payment System (OPPS) – hospital care that is observation, other outpatient care falls here
  - Combination of prospective payments and fee schedule
  - Based on Ambulatory Payment Classifications (APC)
    - Uses procedure codes for payment basis, not diagnoses like MS-DRG, but specificity of diagnoses is important for procedures to be paid
    - Multiple procedures during an OP service are additive, unlike MS-DRG where it is billed as one level of care

Part B: Outpatient Billing of Medicare

- The **physician's care** is billed separately, as delivered day-by-day and is also expressed through the physician's written word showing the history, any examination elements, and the amount of medical decision making that is undertaken in the encounter to support the bill for the services. This is paid under the **Part B** Program (OPPS).
  - True for hospital and office-delivered care

Costs for Patient (2022)

- **Part A**: covers inpatient hospital, skilled nursing care, hospice, inpatient rehabilitation, and some home health
  - Free (>10 yrs employment). But, if you have to purchase it, up to $471/mo
  - Deductible: $1,556/Part A care, no co-insurance (60d), then $389/d for day 61-90. In skilled nursing facilities (SNFs), the first 20d are covered, then on day 21-100, the co-insurance will be $194.50 in 2022.
- **Part B**: covers physician services, durable medical supplies, outpatient laboratory and other hospital services, some home health, therapy, etc.
  - Standard cost: $170.10/month premium (higher depending on income)
  - Annual deductible: $233 per year with 20% of Medicare approved amount as co-insurance per service delivered after deductible met.

https://www.federalregister.gov/public-inspection

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https://www.federalregister.gov/public-inspection **COMPLEX/CONFUSING**

No Surprises Act of 2022

- Protects patients from "surprise bills" esp. when care delivered from out-of-insurance-network providers (emergency situations)
- Out of network care is more costly (co-insurance and total bill amount)
- Allows a chance to dispute a medical bill if it is >$400 more than the good faith estimate that is given up front to the patient before care is given.
  - When the difference in the insurance pay and the bill is sent to the patient, it is called "balance billing" or "surprise medical bill"
  - *No Surprises Act* affords protection from this occurring and helps keep patients informed

CMS.gov/nosurprises,

Medicare … Sustainable?[6, 12]

- Healthcare expenditures are projected to reach $6.19 trillion by 2028 in US (19.7% GDP) estimated annual growth rate of 5.4% since 2019
  - Medicare is projected to be at 7.6%
- Medicare programs are operated through two trust funds
  - Hospital Insurance (HI) trust fund mainly pays for inpatient hospital costs
  - Supplementary Medical Insurance (SMI) trust fund finances physician services, outpatient care, and the Part D prescription drug program
- The 2020 Medicare Trustees Report noted that Medicare's HI trust fund is projected to be depleted in 2026

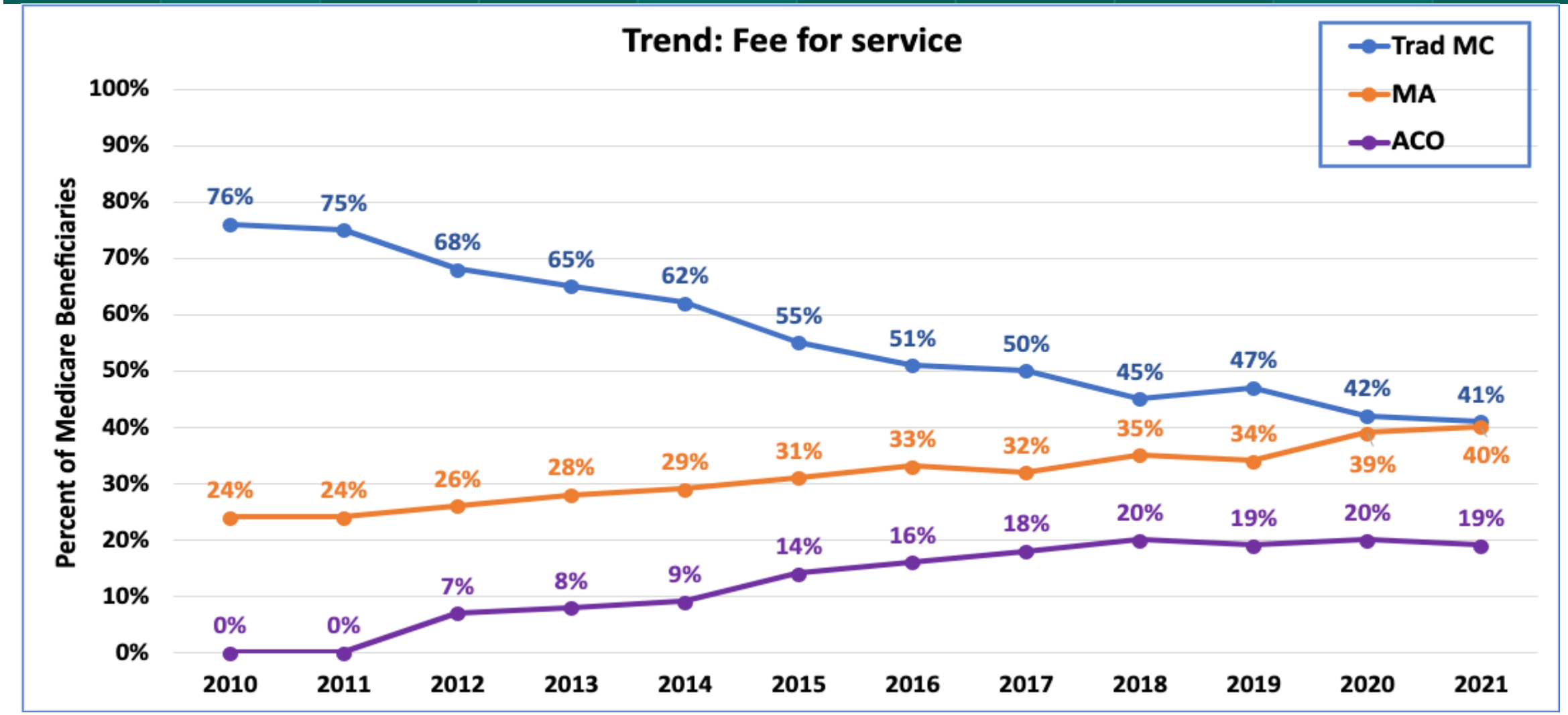
The business of medicine 101 … volume only?[3]

- Is there another way for payment instead of "see more people"… ? Are there other management options to help with sustainability?
  - Yes … "manage care of people"

Part C: Medicare Advantage[1]

- CMS allows Medicare patients to get benefits from commercial insurers. Carriers market to public ("open enrollment") and sign up "members" to their insurance plan. Payment to insurers to care for the Medicare patient comes from CMS and patients
  - Many offer additional coverage over Medicare (hearing, dental, transportation, etc.), care management (care transitions), disease management (DM, COPD, HF, etc.), in-home wellness assessments
  - MA plans "manage" the patient costs of care and utilization -- goal of high quality, lower cost. Unlike Medicare which has less (no) front-end scrutiny; cost containment is major focus
  - If quality and patient satisfaction are above benchmark, and cost is below premium intake, the MA plan can share in the savings ("shared savings") with CMS
  - If Plan gets a 4- or 5-star quality rating, then CMS affords a financial bonus. 5-Star Plans can market year-round and not just in the "open enrollment" period in November-December
- CMS controls which insurer is allowed into the market and under-performers can be withheld from participating in some areas
- Part D: Prescription drug coverage. Optional but offered by many MA Plans

The Path to Value-Based Healthcare



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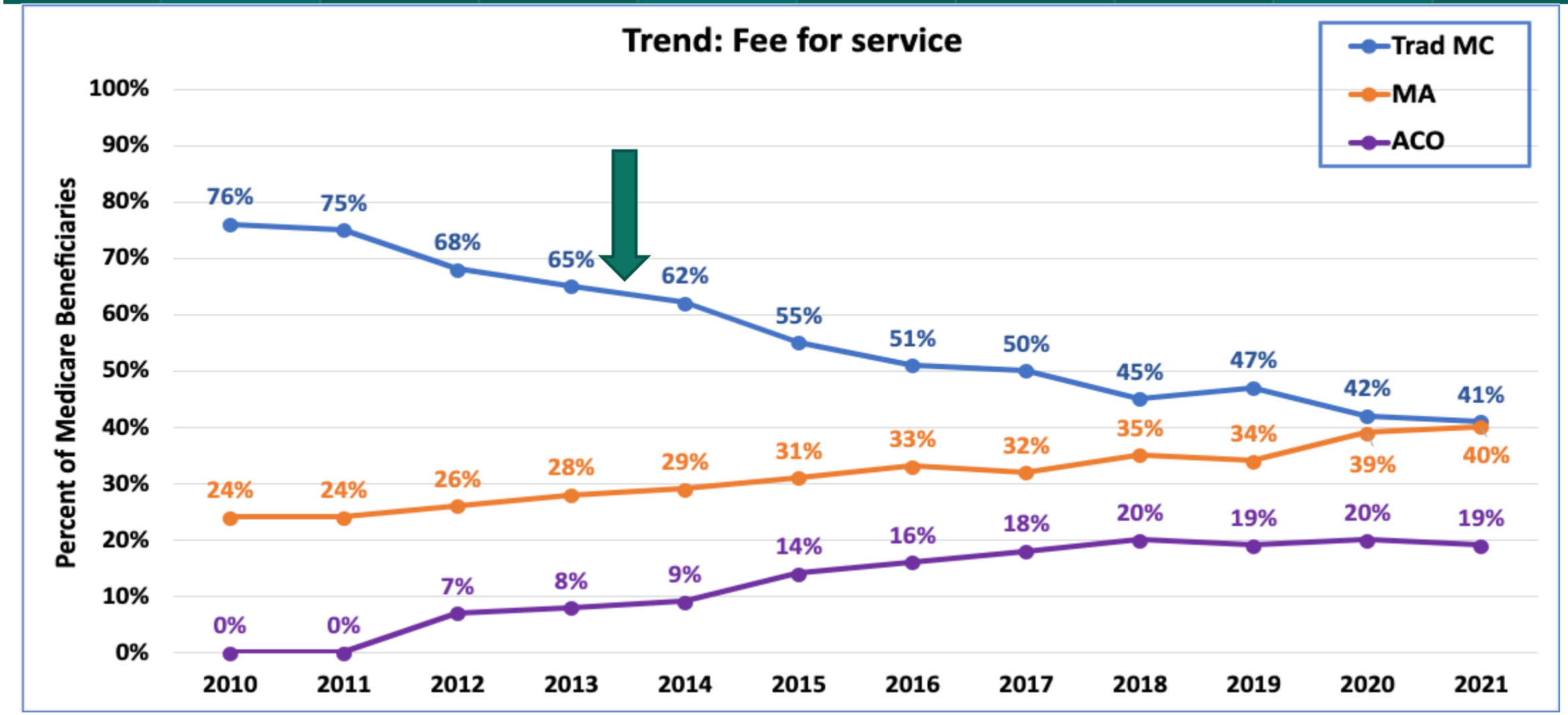

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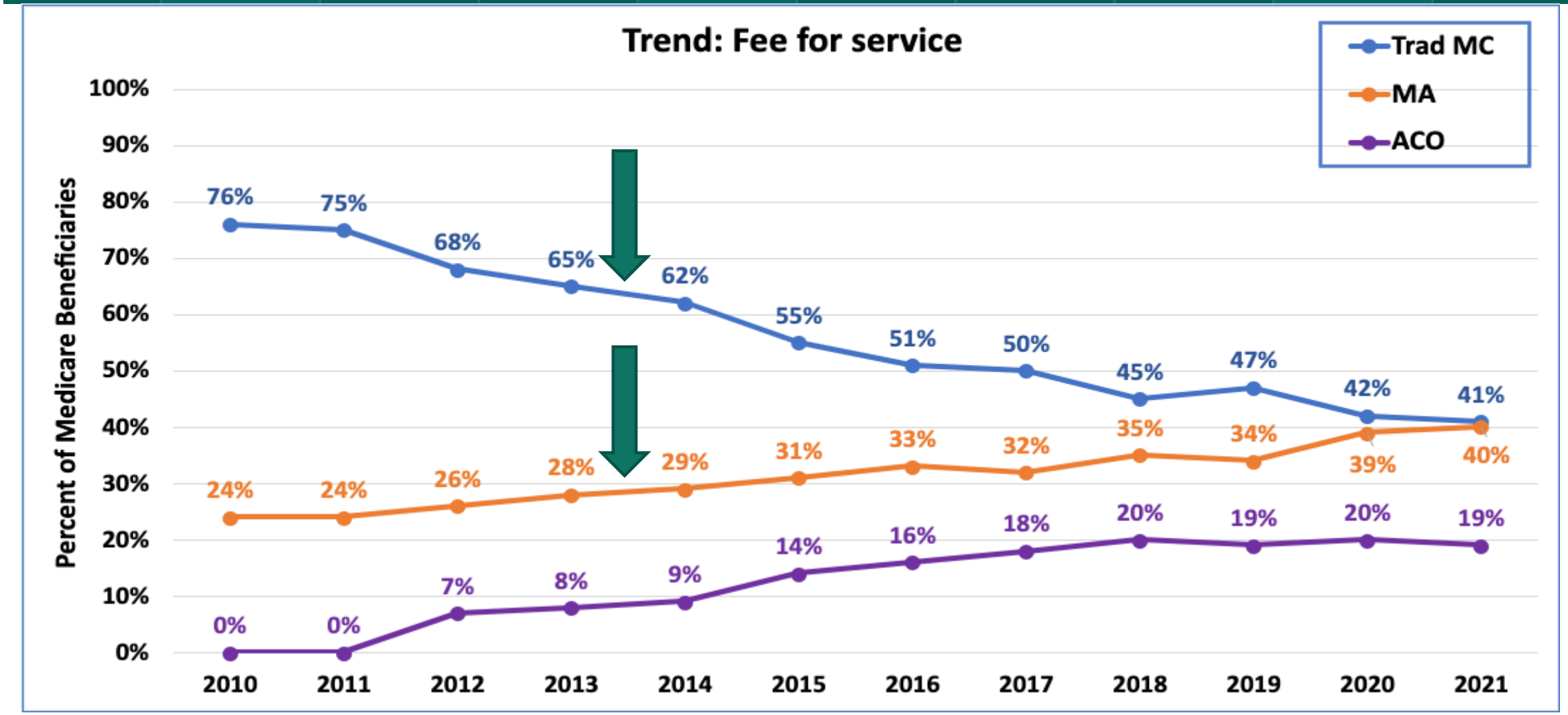

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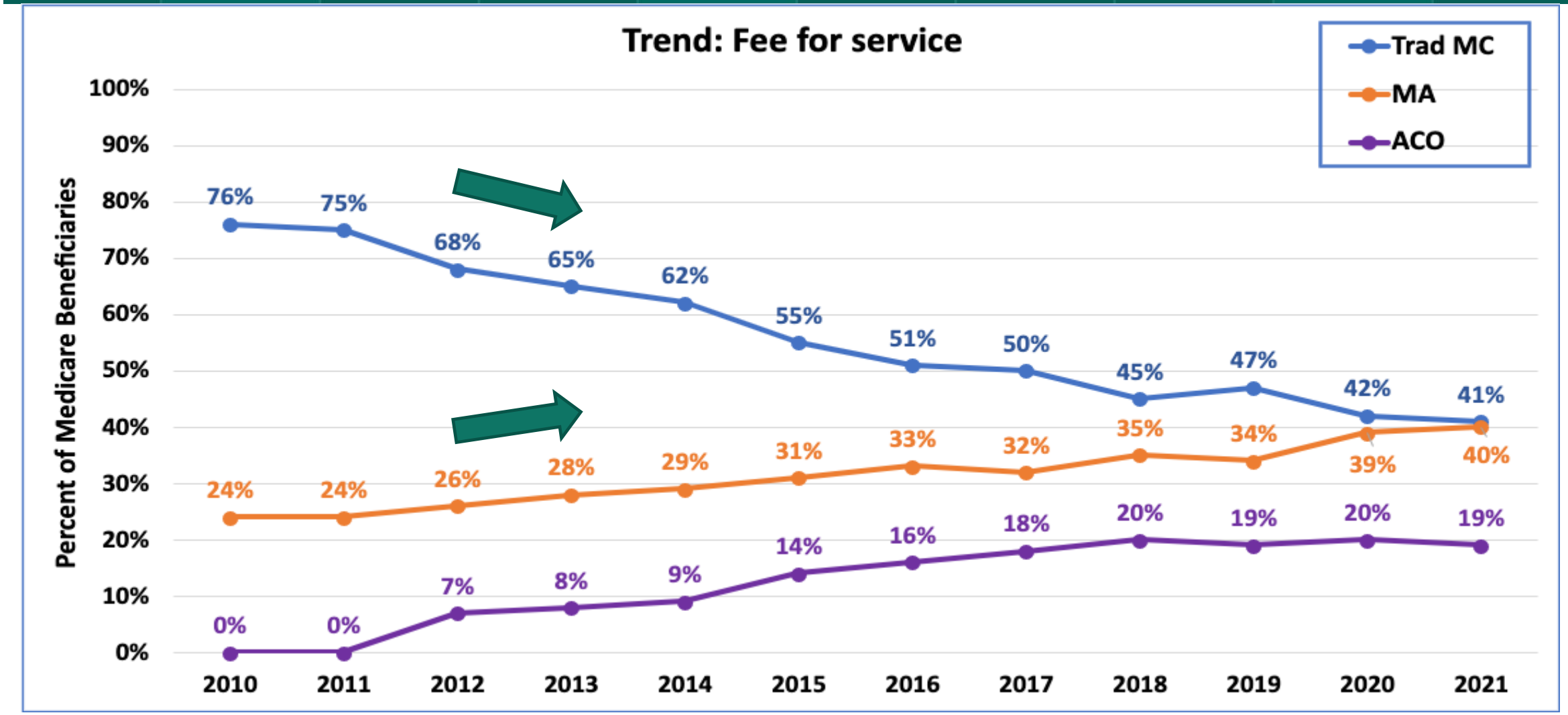

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The business of medicine 101 … volume only?[3]

- Is there another way for payment instead of "see more people"… ? Are there other management options to help with sustainability?
  - Yes … "manage care of people" with more options
- The Affordable Care Act allowed avenues for a different approach
  - Allow doctors, hospitals, and other providers to form networks to coordinate care and work on ways to enhance quality outcomes as they manage costs of care – they are held "accountable" for quality and cost. In the Medicare program these relationships form what are called Accountable Care Organizations (ACOs), and ACOs also can expand into the commercial space as well
  - If quality outcomes are met, then the clinical entity can "share" in any savings that arise because of managing the cost of care
  - Managing cost by managing utilization….
    - Limit ED, use of SNF vs Inpatient Rehab OR Home Health vs SNF (TJR), limit hospitalizations, appropriate testing

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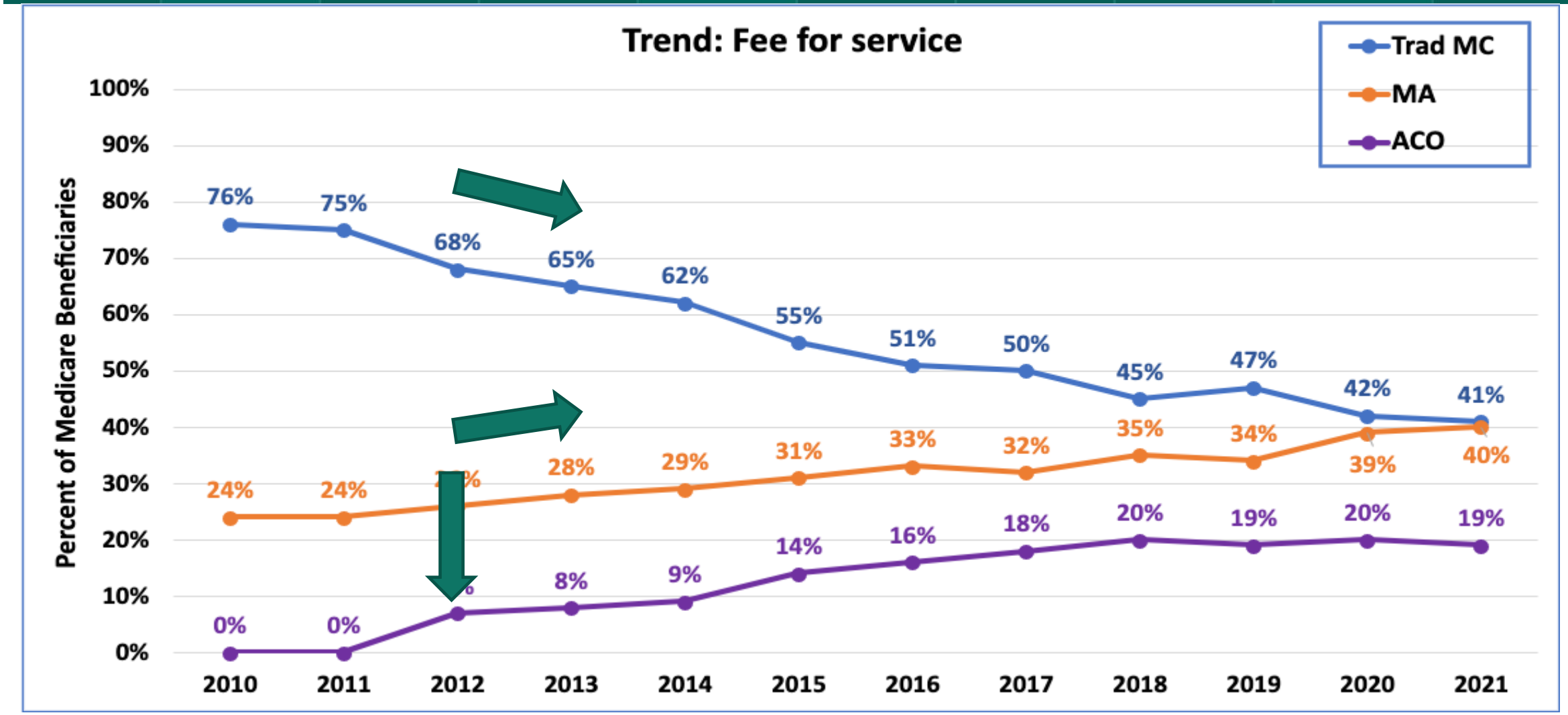

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Not all Profits … What Then?

- If a provider organization does not manage cost well, then the losses are "shared" as well – *downside* risk
  - Anxiety for small groups. Larger groups (ACOs) even have wavered after initially engaging this model
  - Cost containment is more than limiting ED use, readmissions, testing …
    - Catastrophic healthcare costs can balloon expenses: traumatic accidents, cancer, perinatal issues, pandemic (COVID) unknowns
  - Over time, there is less waste to eliminate (so thinner margins, less to "share")

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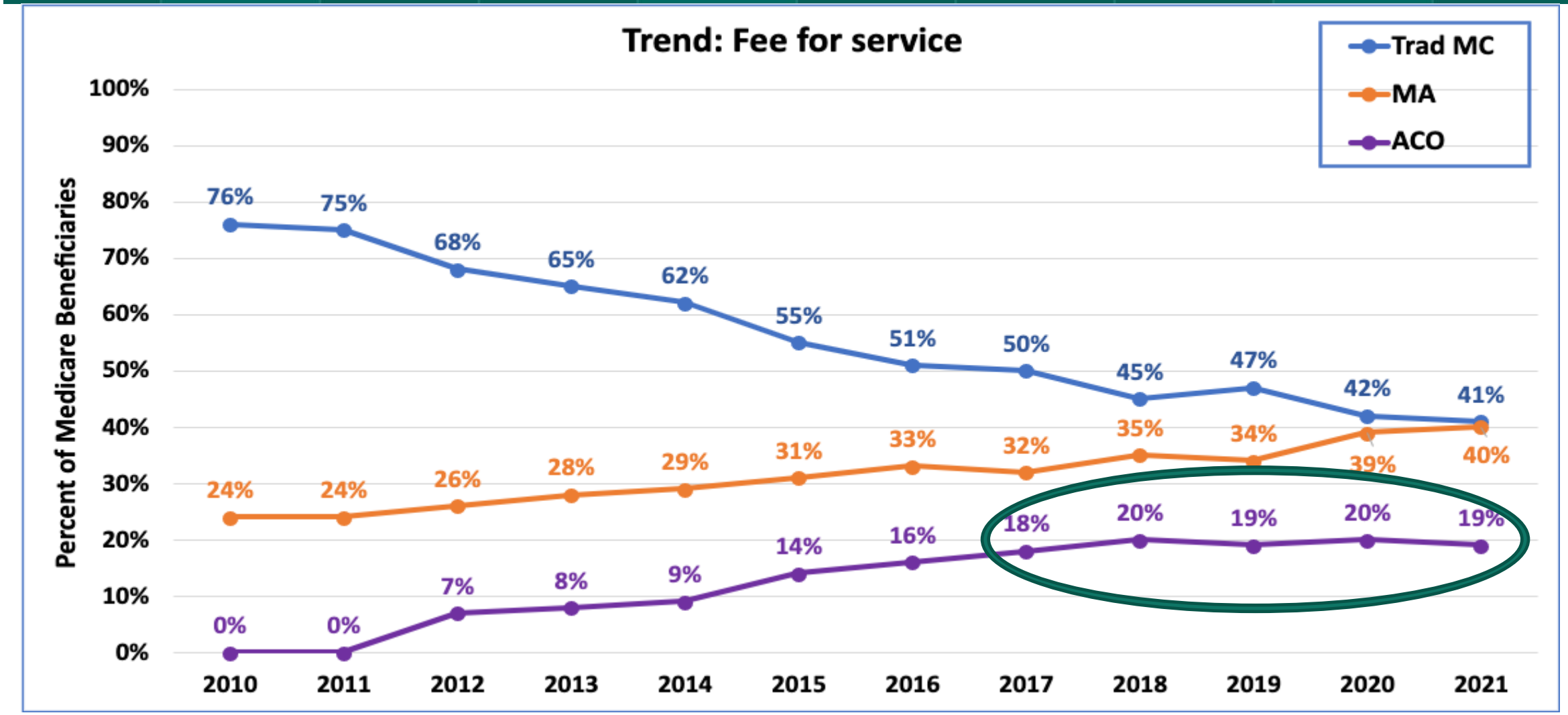

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More Options: Direct Medicare Contractors[9]

- Direct Contracting Global and Professional Options (launched 04/2021)
- Entities with direct contracts with Medicare to manage a population of patents – building on ACO and MSSP models in place
  - Same general set-up as with Medicare Advantage re cost/shared savings and quality, performance, linked to ACO Medicare population
  - Organized care management structure, chronic condition capture (HCCs), focus on high-touch care strategically delivered – innovation as different players allowed in
    - PCP offices, virtual, in-home visits, etc.
    - Focus is on quality, cost, limit ED use and hospitalizations

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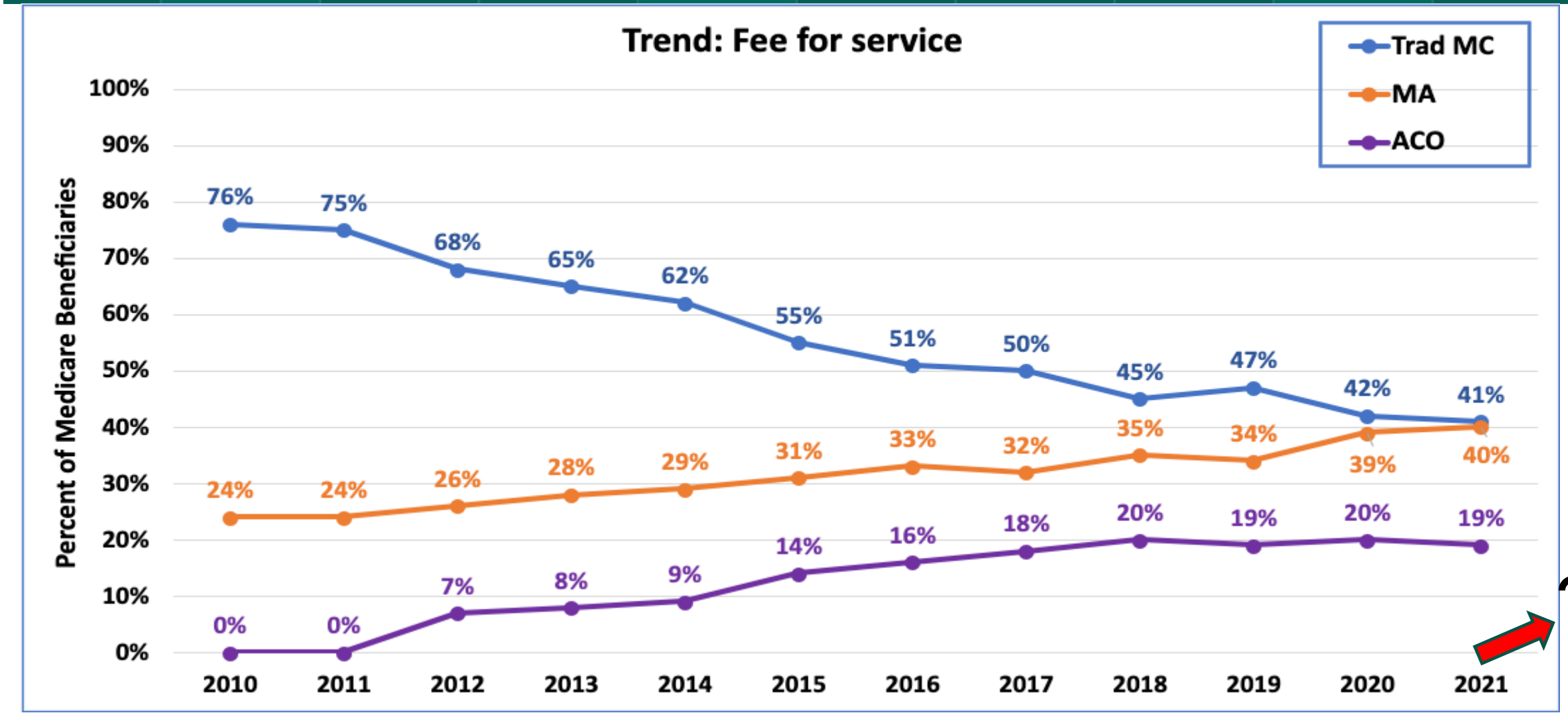

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Others…no insurance: Direct Primary Care (DPC)[10]

- In primary care, a "cash up front" offering that does not take insurance is available
  - An "alternative payment model" of a monthly fee to a provider ("direct") to have access for care.
  - Lower cost, no filing of insurance, usually have some "catastrophic" coverage for hospital/other out of pocket costs
  - More individualized care, providers have smaller panel size and more 1:1 attention can be paid to the patient
- Limited offering in today's healthcare space, but growing, more organized

Physicians Helping the Hospital Get Paid

First, “show your work” regardless to be paid…

- Think in ink to show thought work
  - If not written, credit cannot be assumed, and payment may not follow
    - “medical necessity” is needed to justify the test, visit, admission, procedure, etc.
- ICD-10 diagnoses relate the illness severity
  - “my patients are sicker” is now trackable with ICD-10
  - The story in the chart needs to support the diagnosis
- “Copy and Paste”
  - Auditors use this finding as a reason to deny any applicable medical necessity for the encounter and as such, deny payment
    - Without an Advanced Beneficiary Notice, patients are not responsible

Status determination: Getting into the Hospital

- Provider's documentation must support the order for the "status" or "service" to be delivered to a patient:
  - Surgical care
    - Procedure only: Inpatient only list, documentation to support. Pre-authorization
    - If complex enough, medical care can be added to the surgical care
      - Lap cholecystectomy that had new BP and DM complications can take an OBS procedure and change to IP with documentation of active management > 2MN
  - Sometimes not denied, but "altered"
    - Medical care: documentation of severity/necessity drives IP/OBS
      - Observation services vs Inpatient services (pneumonia vs pneumonia…)

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Patient responsibility and hospital reimbursement is affected based on the clinical situation and the provider's documentation.

More Than Status and Necessity…MS-DRGs[2]

- **MS-DRGs**: Medicare Severity Diagnostic Related Groups are based on hospital-based services and the diagnosis codes are identified as only those as part of the reason for the treatment or procedure
  - Used since 1982 to replace "cost based" reimbursement
  - Payment categories used for the purpose of reimbursing hospitals for each case with a fixed fee regardless of the actual costs incurred
  - Principal diagnosis and all secondary diagnoses and procedures related to the admission
  - Have comorbidities and complications (CCs) and Major comorbidities and complications (MCCs)
    - Appropriately capturing the CCs and MCCs in a patient's condition will best align the DRG to a patients clinical condition

DRG focus on specificity

- AMS → Delirium d/t _____ (CC) → toxic encephalopathy (MCC)
- Slurred speech → TIA (CC) → Cerebral infarction (MCC)
- CHF→ Systolic/Diastolic HF (CC) → Acute systolic HF (MCC)
- Hypoxemia → Chr. resp fail (CC) → Acute on chronic resp fail (MCC)
- Hypoperfusion → shock, unsp (CC) → cardiogenic shock (MCC)
- CKD Stage I-III → Stage IV,V (CC) → ESRD (MCC)

Hospital Payment: CMI^2

- **CMI:** Case Mix Index is the average relative DRG weight of a hospital's inpatient discharges, calculated by summing the MS-DRG relative weight for each discharge and dividing it by the total number of discharges.
- The CMI reflects the diversity, clinical complexity, and resource needs of the patients in a given hospital.
- A higher CMI reflects a more complex, resource intensive (sicker) case load. They are applied to all discharges regardless of payor, even though this was designed for Medicare patient
- Higher CMI → higher reimbursement for all clinical work performed

Hospital Management: LOS[2]

- The "length of stay" (LOS) is the time that a patient is in a facility setting receiving care
- The sicker the patient (per DRG), the longer the expected LOS
- LOS as a global system measure is fraught with irregularities, best to look at disease specific LOS
- The Geometric Mean LOS (GMLOS): national mean LOS for a DRG, determined by CMS. Not a straight average but eliminates outliers (very short/long stays). Since CMS national, we can compare
- GMLOS is an efficiency measurement and should be part of the care team discussion
- Milliman Care Guidelines® have the Optimal Recovery Course as a guide to start

Getting Paid: The Physician

Physician payment: Volume From RVUs[7]

- Relative Value Units (RVUs) helps devise the payment formula to obtain reimbursement and is still the primary way physicians are paid
- Historically, a private group of 32 (mostly specialists) physicians—the AMA's Specialty Society Relative Value Scale Update Committee (RUC)[8] – have largely determined Medicare's RVU physician work values
- Three components to the RVU:
  - Physician work – work RVU (wRVU) – key measure for most physician base compensation
  - Practice Expense – PE RVU
  - Malpractice Expense – MP RVU
- The three RVUs for a given service are multiplied by a unique geographic practice cost index (GPCI)
  - Account for differences in overhead costs in varied regions
- The three GPCI-weighted RVUs are added together to get a "total" RVU
- The total RVU is multiplied by a conversion factor (CF) to get the final price paid for a service (99214, for example) – CF set by CMS yearly and is applied across the spectrum of healthcare as the amount paid per RVU

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The provider's cost is added to costs from the facility (outpatient center, hospital, etc.) "Professional Component" of charge

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The Conversion Factor for 2022

- Volatility with Conversion Factor (CF) in 2021 and 2022 as Congress has stepped in late each year to alter the CF
  - On 12/09/2021, the proposed 3.75 % reduction in the CF was reduced to 0.75%
    - Was to be taken from $34.89 → $33.59, but with Congressional action is at $34.60 for PY2022 (www.congress.gov/bill/117th-congress/senate-bill/610/text)

Our own survival

- We see patients to deliver excellent clinical care and make a difference in our community. But, we have to make our bottom line.
- We gather revenues by seeing patients (volume) and billing them for the clinical services we deliver.
- 2021: Office evaluation and management billing services changed. Hospital-based codes did NOT (maybe 2023…?).
  - For ambulatory, understanding of the two ways to bill (Time OR Medical Decision Making) to get paid for the clinical care you are delivering
  - Overcharging is incorrect (if known and you continue, fraudulent) and undercharging is inappropriate

Getting paid with our "story"

- We must be proficient in documentation of our thought work since payors can audit our documentation to see if there is "medical necessity" for the tests, etc. we order.
  - From a compliance (and revenue cycle) standpoint, having an external coding entity do an audit is a best practice when new providers come in, when new codes are deployed that affect your office (2021 changes…), or when you feel that there is an outlier in your provider ranks (E&M trend comparisons)
- When doing "additive" work, add modifiers and document well (ex., -25)
  - Medicare Wellness and chronic disease. E&M and procedures.

The business of medicine 101 … quality incentives?

- Quality metric attainment is usually a part of the payment calculation as well as cost management
- Some insurers incentivize providers to meet targets to help promote quality and allow for additional revenue opportunities
  - Meeting 4 or 5-Star quality ratings gets Medicare Advantage plans bonuses from CMS
  - What measures…what thresholds..? Stay tuned for session #2….

Getting Paid: The Insurance Company

Getting Paid: The "Insurance Company"

Whomever is Managing the Premium

The Funds Flow 101

- Every insurer must manage the money coming in (the premium) with the money going out (payments for claims/services rendered - expenses)
  - With direct Medicare contracting, more options for providers to manage the money
- If the cost of the plan (premium) is too high, then the product won't be successful in the market
- If the cost is competitive, but the payouts are too great (higher utilization), then the margin (premium – utilization cost = profit) suffers

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- Every insurer must manage the money coming in (the premium) with the money going out (payments for claims/services rendered)
- If the cost of the plan is too high, then the product won't be successful in the market
- If the cost is competitive, but the payouts are too great (higher utilization), then the margin (**premium** – utilization cost = profit) suffers
- BUT, if we could *increase the premium*, then there may be more profit

Physicians Managing Premium

- If we use Medicare/Medicare Advantage and the "ACO" as a model, monies must come in to pay claims….
- Revenues (monies) come in via fees (premiums/co-pays) paid by members. CMS also provides a per member per year "budget" for MA plans to manage the cost of care for a beneficiary.
- The MA "budget" is aligned with the clinical condition(s) that the beneficiary has. The clinical condition is "weighted" through the use of diagnosis code capture.
  - More complex conditions (diabetes with nephropathy) cost more to manage than other conditions (impaired glucose tolerance).
  - The higher complex code will have more money provided to manage the care because it carries more "risk" in management.

Show Your Work

- The base rate of PMPY premium coming in is adjusted up/down based on the "risk score"
  - Risk score comes from the diagnoses listed on the claim: DM with nephropathy vs. DM vs. Impaired glucose tolerance – more complex conditions have higher risk scores, and the associated higher premium would increase to help manage the care
    - IGT < DM < DM w nephropathy (lower→higher risk value)
  - Used in measurements of various physician quality metrics as well (readmits, MSPB)

Why is "Risk Stratification" Important?

- In the world of "population health management", the practice of medicine is being defined as
  1. Best quality
  2. Most optimal cost (cheapest)
  3. Satisfied patients
  4. Satisfied providers (physicians, NPPs, facilities)

...with a realization that sicker patients will cost more to care for and thus, a "weight" or "risk score" is needed to apply that cost credit

- Patients with more severe illnesses should have ICD-10 diagnosis codes to show the level of illness – some of these diagnoses have "risk" and are labeled as hierarchical condition categories (HCCs)
  - Diabetes vs. Diabetes with nephropathy

Why is "Risk Stratification" Important?[5]

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- Patients with more severe illnesses should have ICD-10 diagnosis codes to show the level of illness – some of these diagnoses have "risk" and are labeled as hierarchical condition categories (HCCs)
  - Diabetes (0.105) vs. Diabetes with nephropathy (0.302)

Diabetes Focus: HCC score[5]

- Diabetes with acute complication 0.302
  - BS 322, DKA, A1c 10.1
- Diabetes with chronic complication 0.302
  - DM with B peripheral LE numbness mid-foot distally
- Diabetes without complication 0.105
  - 43% of the time
- The difference annualized with the correct HCC is 0.197 or $1,841* each diabetic patient that falls into this category
  - For 100 incorrect DM patients is $184,100 over a year of "lost premium" to manage this population

$9,350 PBPY rate for calculation

HCC: Tied to Premium Dollars to Manage Care

- Medicare Advantage Plan A:
  - 15,000 patients with an average rate of $10,000/patient (PMPY), average healthy patient is a risk score of "1.0", so the risk of "1.0" = $10,000. If 15K patients, then there is $150M allotted for care (15K pt x $10K/PMPY).
- If we focused attention on key diseases, and improved the chronic condition capture by 0.01 (1%), then the average patient would be 1.01 (instead of 1.00).
  - $10,000 X 1.01 = $10,100/PMPY x 15,000 patients = $151.5M (up from $150.0M with a risk of 1.0) → $1.5M added premium to take care of the patient's needs

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  - $10,000 X 1.01 = $10,100/PMPY x 15,000 patients = $151.5M (up from $150.0M with a risk of 1.0) → $1.5M *added premium* to take care of the patient's needs
  - All because the providers captured the severity of the illnesses before them

Show Your Work

- The base rate of PMPY payment is adjusted up/down based on the "risk score" assigned to the patient – and is adjusted yearly. Redocument!
  - Risk score comes from **diagnoses** listed **on the claim**:
    - DM with nephropathy **>** DM **>** Impaired glucose tolerance
- Failure to diagnose to the highest level of specificity
  - Can negatively impact revenues for the plan management (downstream)
  - Can negatively show the severity of the panel of patients you are managing (quality)
- Are there specific conditions we need to focus on to align with our health plan partners….?

Key Areas ***Not*** to Miss (yearly update)

- Amputations (AKA, BKA, toes) and how it affects functional state
- ***BMI, especially 40+ with a plan to address***
- Asthma and pulmonary conditions
- ***CHF: specifying type (systolic or diastolic) and condition (acute/chronic)***
- Ostomy: urostomy, cystostomy, tracheostomy, ileostomy, gastrostomy with a status/condition
- Transplanted organs: heart, liver, lung, pancreas, bone marrow (not kidney!) and status
- Functional quadriplegia: complete inability to move due to disability (not neuro)
- ***Stage III,*** IV, and V kidney disease ***(silent disease)***
- ***Acute DM complications***: symptomatic w/ BS <70 or BS > 140mg/dl or DKA or ***DM with complications*** (nephropathy, retinopathy, neuropathy, etc.)
- Rheumatoid Arthritis

Closing Comments

- The Business of Medicine is complex … Not taught this in medical school, residency, or post graduate training .. It is evolving
- For us: Focus on quality…Pay attention to cost ... Focus on the patient
  - Code and bill correctly so funds will flow in
  - Capture our diagnoses to show our "work" – "risk" scores matter (DRG or HCC)
  - Right test, right time, right place
- Look for workflow inefficiencies – volumes and throughput matter
- Understanding of the basic workings of the systems we live in are key to us assisting in the successful management of the patients we are called to care for

Closing

- Thanks for inviting me and listening in!
- Questions ….?
  - Nick Ulmer, MD CPC FAAFP
  - NUlmer@protimellc.com

Resources

1. **2022 Medicare Parts A & B Premiums and Deductibles - Nov 12, 2021 (https://www.cms.gov/newsroom/fact-sheets/2022-medicare-parts-b-premiums-and-deductibles2022-medicare-part-d-income-related-monthly-adjustment)**
2. **Pinson and Tang; 2022 CDI Pocket Guide, pp 23-26, 31-35.**
3. **What is an ACO? (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO)**
4. **HEDIS and ACO Quality 2022 Measures. (https://www.ncqa.org/hedis/measures/ and https://www.naacos.com/assets/docs/pdf/2021/ACO-QualityChanges2021_2022.012521.pdf)**
5. **Report to Congress: Medicare Advantage Risk Adjustment – December 2021 (https://www.cms.gov/files/document/report-congress-risk-adjustment-medicare-advantage-december-2021.pdf)**
6. **Keehan, SP, Cuckler GA, Poisal JA, et. Al. National health expenditure pojections. 2019-28. *Health Affairs 2020; 39(4):704-14.***
7. https://cpt-international.ama-assn.org/relative-value-units
8. https://www.ama-assn.org/about/rvs-update-committee-ruc/composition-rvs-update-committee-ruc
9. https://innovation.cms.gov/innovation-models/gpdc-model
10. https://www.dpcare.org/
11. https://www.ma-pdpcahps.org/en/Current-Data-Collection-Materials/
12. https://www.actuary.org/node/13472

TNAFP 2022 Annual Practice Enhancement Seminar

Understanding the Business of Medicine

Nick Ulmer, MD CPC FAAFP

VP, Clinical Integration and Medical Dir., Case Mgmt SRHS

Chief Medical Officer, Regional HealthPlus PHO

2022 Stars and MSSP ACO Measures

Measure	Program		Star Category & Weight		2021 MSSP	Thresholds 10/4/2021	
	Stars	ACO	Part C or D?	Weight	Threshold	4 Star	5 Star
Care for Older Adults - Functional Status Assessment	✓		C	0		85%	93%
Care for Older Adults - Medication Review	✓		C	1		84%	95%
Care for Older Adults - Pain Assessment	✓		C	1		87%	96%
Medication Adherence for Diabetes	✓		D	3		87%	91%
Medication Adherence for Hypertension (RAS)	✓		D	3		87%	90%
Medication Adherence for Cholesterol (Statins)	✓		D	3		87%	91%
Medication Reconciliation Post-Discharge	✓		C	1		69%	82%
Plan All-Cause Readmissions	✓		C	0		7%	3%
Osteoporosis Management in Women w/ Fracture	✓		C	1		50%	68%
Statin Use in Persons with Diabetes	✓		D	1		84%	88%
Diabetes Care - Kidney Disease Monitoring	✓		C	1		94%	97%
Diabetes Care - Eye Exam	✓		C	1		71%	79%
Diabetes Care - Blood Sugar Controlled	✓	✓	C	3	<23%	72%	81%
Breast Cancer Screening	✓	✓	C	1	70%	69%	76%
Colorectal Cancer Screening	✓	✓	C	1	65%	71%	80%
Controlling Blood Pressure	✓	✓	C	3	70%	75%	82%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	81%	84%	89%
Reducing the Risk of Falling		✓			70%		
Depression Screening		✓			70%		
Influenza Immunization		✓			75%		
Tobacco Screening and Cessation Intervention		✓			75%		