MIPS, APMS, QRUR, and CMS Data: How Do Your Physicians Compare?

Auditing Quality: The Quality Payment Program

- Quality Payment Program 2017 - and beyond
- Audit Points: QPP Implementation
- Big Data and Doctors On-Line
- Malpractice and Quality
- Conclusions

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Speaker's CME Disclosure

- Michelle Moses Chaitt, J.D. and D. Scott Jones, CHC, have no financial conflicts to disclose.
- Attendees are not charged for this presentation, it is provided as a service.
- This presentation is not offering medical, legal, accounting, regulatory compliance or reimbursement advice or attempting to establish a Standard of Care. Please consult professionals in these areas if you have related concerns.

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Quality and Value Healthcare – 2017 and Beyond

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The Future of MACRA Payment Reform

- In 2015, MACRA passed 92-8 in Senate and 392-37 in House.
- MACRA repealed the unsustainable "Sustainable Growth Rate" or SGR formula, which could have resulted in a 21% Physician Fee Schedule reduction in 2015.
- 2017 is the MACRA transition year and programs are in place to shift provider payments to the Quality Payment Program.

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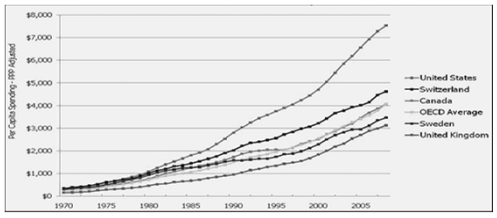
Cost: U.S. Healthcare Cost per capita <u>doubles</u> that of other developed nations



Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted. Break in series: CAN(1995); SWE(1993, 2001); SWI(1995); UK (1997). Numbers are PPP adjusted. Estimates for Canada and Switzerland in 2008.

Source: Organization for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database). doi: 10.1787/data-00350-en (Accessed on 14 February 2011).

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Medical Over-Utilization: Healthcare Compliance Investigations recover $3B / year

- DOJ recovered *more than $3.5 billion* in FY 2015 alone.
- Continues 4-year record of recoveries over $3 billion
  - $1.9 billion from physicians and providers
  - $330 million from hospitals
  - $2.8 billion (more than half) from cases filed by whistleblowers
- Number of *qui tam / whistleblower* suits exceeded 600
  - Whistleblowers received record $597 m

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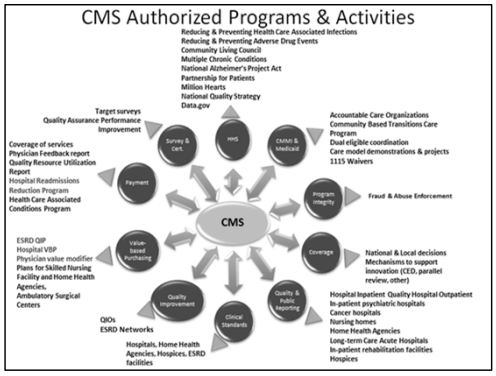

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The CMS Quality Payment Program (QPP)

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2017: The Quality Payment Program (QPP)

- **Rulemaking enacted by CMS under MACRA**
- **MACRA Repealed** the Sustainable Growth Rate (SGR) Formula
- **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS):
  - Physician Quality Reporting Program (PQRS)
  - Value Based Modifier (VM)
  - Medicare Electronic Health Records (EHR) Incentive Program
- **Provides incentive payments for participation in Advanced Alternative Payment Models (APMs)**

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

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QPP Participation

- Not participating in the QPP in CY 2017 will result in a negative -4% payment adjustment to the Physician Fee Schedule in CY 2019.
- Physicians should:
  - Determine if they wish to report by joining an Advanced Alternative Payment Model (APM) program, such as an ACO, or report independently through the Merit Based Incentive Program (MIPS).
  - Determine if they wish to report through a clinical data registry.
  - Consult with their current EMR vendor to determine what registries and MIPS reports are supported.

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Individual or Group Reporting

- Physicians may report individually on quality measures -
- Or, Groups may report as a group under one Tax ID number (TIN).
- Note that individual physicians will receive a group score rating. High performers or low performers may be positively or negatively affected by the group score.

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Audit Points:

- Reporting: MIPS or APMS?
- Reporting: Clinical Data Registry or Data Submission by Practice?
- EMR: What Registries and MIPS or APMS will the current EMR vendor support?
- Reporting: Individual or Group?
- Comparing Scores:
  - Which reporters achieve a better score as an individual?
  - Which reporters are low achievers?

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Who Participates in MIPS?

- Medicare Part B clinicians (paid under the Medicare Physician Fee Schedule, PFS) billing more than $30,000 a year and providing care for more than 100 Medicare patients a year.
- These clinicians include:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Certified Registered Nurse Anesthetists

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Quality-Payment-Program-webinar-slides-10-26-16.pdf

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Who is Excluded from MIPS?

- Newly-enrolled Medicare clinicians
  - Clinicians who enroll in Medicare for the first time during a performance period are exempt from reporting on measures and activities for MIPS until the following performance year.
- Clinicians below the low-volume threshold
  - Medicare Part B allowed charges less than or equal to $30,000, or who treat 100 or fewer Medicare Part B patients
- Clinicians significantly participating in Advanced APMs.
- Health Professional Shortage Area (HPSA) exceptions
  - Rural Health Clinics, Federally Qualified Health Centers, Critical Access Hospital may have an exception.

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Audit Points:

- Identify and exclude new clinicians enrolled in Medicare for the first time.
- Establish a MIPS or APMS training process for those doctors, so they can achieve maximum scores when they start reporting. Identify reporting start dates.
- Identify clinicians who do not meet the low-volume thresholds. Monitor changes to ensure they begin reporting if they exceed the low volume limits.

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MIPS Scoring

- Providers may attain a 100% score when reporting under MIPS. 2017 data will impact 2019 reimbursement.
- Four measurement categories include:
  - **Quality** (60% for 2017)
  - **Advancing Care Information** (ACI, renamed from Meaningful Use) (25% for 2017)
  - **Clinical Improvement Activit**ies (CPIA) (15% for 2017)
  - **Cost** (0% for 2017, but will be weighted for 2018 and beyond)

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APM's Explained

- Exempt from MIPS reporting.
- Includes payment models managed by CMS:
  - CMS Innovation Center Model (other than a Health Care Innovation Award)
  - Medicare Shared Savings Program Accountable Care Organizations (MSSP ACOs)
  - Demonstration under the Health Care Quality Demonstration Program
  - Demonstration required by federal law

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Advanced APM's

- A subset of APM's, which also:
  - Require participants to use certified EHR technology
  - Bases payment on quality measures, comparable to those in the MIPS Quality performance category
  - APM members bear more than nominal financial risk for monetary losses
  - Or, the APM is a Medical Home Model expanded by the CMS Innovation Center
- APM's and Advanced APM's may earn a +5% annual bonus

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How does the Payment Adjustment work?

- Data submitted affects payment two years later. 2017 data affects 2019 payment.
- CMS sets a performance threshold number of points that must be earned through MIPS reporting (maximum=100)
- Each point above the Performance Threshold (PT) = higher incentive payments.
- Each point below the PT = lower payments.
- Physician scores will be posted on sites like Physician Compare and are downloadable by the public.

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What is the Projected PT Range of Payments?

- 2017 Transition Year Range (3 to 70 points)
  - -4% (no participation)
  - +5%
- 2018 Projected Range (0 to 100 points)
  - -5%
  - +10%
  - Additional +5% bonus for a final score of 100
- 2020 Projected Range (0 to 100 points)
  - -5%
  - +9%
  - Additional +10% bonus for a final score of 100

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Budget Neutrality

- MIPS penalties assessed to poor performers will be used to pay incentives to positive performers.
- MACRA calls for the QPP to be budget – neutral (does not increase the overall CMS budget).

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Audit Points:

- Physician MIPS Points
- Percentage of payment increase or decrease, by physician
- APM Reporting criteria and performance

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Quality Payment Program Home Page

- CMS provides a comprehensive Home Page for QPP information.
- **https://qpp.cms.gov/**

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QPP Implementation

Transitional Year 2017: Pick Your Pace

- Reporting under MIPS or APMS began January 1, 2017.
- APM models will have individual program deadlines. Consult your APM reporting standards.
- For MIPS, physicians have three choices:
  - **Test Pace: Report some data.** Expect a 0 or small negative payment adjustment for 2017.
  - **Partial Year: Report for a 90 day period.** Expect a small positive payment for successful reporting. Last date: October 2, 2017.
  - **Full Year: Full participation and report**ing can result in a modest positive payment adjustment.
- No participation: Negative - 4% payment adjustment.

https://blog.cms.gov/2016/09/08/qualitypaymentprogram-pickyourpace/

Group Practice Reporting Option (GPRO)

- Physicians must decide if they wish to report independently, or as a group.
- If physicians choose the Group Practice Reporting Option, this must be declared to CMS by June 30, 2017.
- Physicians must declare only if they use the CMS GPRO Web Interface (Physician Quality Reporting Portal), or if they use the CAHPS for MIPS survey process.
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html

Reporting Due Date

- Data Submission date for 2017:
- March 31, 2018
- Data submission dates for subsequent years will also fall on March 31 of the year after the performance measure year.

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Earning Positive Adjustment

- Positive adjustments are determined by the actual performance data submitted, NOT the:
  - Amount of data
  - Length of time submitted
- Best performance can occur by participating fully, and submitting data on all MIPS performance categories.

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Audit Points:

- Which Reporting Pace?
  - **Test Pace: Report some data.** 0 or small negative payment adjustment for 2017.
  - **Partial Year: Report for a 90 day period.** Small positive payment for successful reporting. Last date to choose this option: October 2, 2017.
  - **Full Year: Full participation and reporting:** 2017 modest positive payment adjustment.
- Individual or Group Reporting?
- Quality of Data Submitted?

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Audit Points: Pick Quality Reporting Measures

- Physicians: Pick up to 6 reporting measures, including an outcome measure, for at least 90 days.
- Groups: report 15 quality measures, for a full year.
- Groups in APM's: Report through APM.
- Quality Measures list and selection tool are available at:
- **https://qpp.cms.gov/measures/quality**

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Audit Points: Attest to Improvement Activities

- Physicians and most Groups: Attest completion of up to 4 improvement activities for a minimum of 90 days.
- Groups <15 participants or in rural or HPSA: Attest completion of 2 activities for a minimum of 90 days.
- Groups in APM's: Full Credit is given based on APM requirements.
- Improvement Activities list and selection tool are available at:
- **https://qpp.cms.gov/measures/ia**

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Audit Points: Advancing Care Information

- For a minimum of 90 days, complete:
  - Security Risk Analysis
  - E-Prescribing
  - Providing Patient Access
  - Sending Summary of Care
  - Requesting / Accepting Summary of Care
  - For additional credit, choose up to 9 measures for 90 days
  - For bonus credit, report public health or clinical data registry reporting measures, or use Certified EHR technology for improvement activities.
- **https://qpp.cms.gov/measures/aci**

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Audit Points: Cost

- Cost data is calculated by CMS using actual Medicare claims submissions.
- Focus on:
  - Avoiding unnecessary tests services, referrals, hospitalizations
  - Reduce clinical variability by using approved Clinical Practice Guidelines (CPG's)
  - Improve cost containment measures in the practice
- **https://qpp.cms.gov/measures/performance**

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QPP: MIPS and APM Educational Resources

- Visit the Educational Resources section of the QPP home pages to view the official rules, MACRA legislation, webinars, educational programs, video libraries, documents and downloads:
- **https://qpp.cms.gov/resources/education**
- View a comprehensive list of APM's operated by CMS, and learn more about Advanced APM's:
- **https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf**

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Big Data
Doctors On-Line

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Audit Points: Physician Compare

- JAMA: 65% of consumers are aware of online physician rating sites. 36% of consumers have used a ratings site at least once.
- Patients are seeking more transparency in physician quality and cost.
- Poor MIPS scoring and quality data (reported online by CMS) may take years to improve or reverse.
- Positive quality data reported online can be a competitive advantage.
- JAMA. 2014; 311(7):734-735.

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Audit Points: MIPS Scores Follow Physicians

- CMS ties MIPS score to the reporting physician for each performance year.
- If the physician changes organizations before the associated payment year (two years after the performance year), the MIPS score and associated payment adjustment follow to the new organization.
- Check MIPS scores for physician recruiting, credentialing, contracting, and compensation plans.
- MIPS scores are part of a physician's profile and public reputation for the succeeding two years after that score is earned.

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Audit Points: Reporting MIPS Quality

- MIPS uses quality measure and reporting from the Physician Quality Reporting System (PQRS) and the Value Based Purchasing programs.
- Report on 6 measures.
- Report on one outcome or high priority measure.
- Each measure assigned 10 possible points.
- Bonus points available for certain quality reporting
  - High priority measures (up to 10%)
  - End to end electronic reporting (up to 10%)

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Audit Points: Advancing Care Information (ACI)

- ACI was previously known as Meaningful Use.
- Now is a scoring system where meaningful use measure rates are compared to benchmarks, as in MIPS quality.
- 131 ACI Performance Points:
  - Base Score of 50 points for select measures from MU Stage II or Stage III measure sets
  - Performance Score up to 90 points for performance on 8 measures
  - Bonus Points up to 15 points for reporting to a public health registry and joining the CMS Clinical Practice Improvement Activities (CPIA) measurement study

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Audit Points: Improvement Activities (IA)

- IA can earn 20 to 40 points (depending on size, location)
  - Small practices, <15 physicians, rural or HPSA must earn 20 points to obtain full credits
  - All other MIPS eligible physicians must earn 40 points to obtain full credits
- IA Reports can include:
  - Combination of medium and high-weight activities (10-20 each)
  - Certain APM's receive 40 points credit (Shared Savings, Oncology Track)
  - Other APM's receive 50% credit, and may report additional activities to gain a full score

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Audit Points: Measuring and Considering Cost

- 2017 Cost weighting = 0, to prevent penalties during the transition year.
- 2018 Cost weighting = 10%.
- CMS rates physicians, based on 40+ cost measures, based on claims submitted to CMS.
- Cost data is taken from actual Medicare Claims.
- Accurate, careful consideration must be given to all services provided beneficiaries. Physicians are now incentivized to avoid unnecessary tests, admissions, or services.

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A MIPS Final Score Calculation - Example

- Quality: 42 of 60 points x 60% weight x 100
- = 42 points
- ACI: 50 of 100 points x 25% weight x 100
- = 12.5 points
- IA: 30 of 40 points x 15% weight x 100
- = 11.25 points (rounds up to 11.3)
- Cost: 14 of 20 points x 0% weight (in 2017 only) x 100
- = 0 points
- Total MIPS Points 2017: 42+2.5+11.25+0 = 65.8

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Malpractice and Quality

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CPG's and the National Institutes of Health

- "Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." *(Institute of Medicine, 1990)*
- NIH Website provides:
  - Standards for Developing Guidelines
  - Specialty Specific Guidelines
- **https://nccih.nih.gov/health/providers/clinicalpractice.htm**

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Clinical Practice Guidelines (CPG's)

- Agency for Healthcare Research and Quality (AHRQ) maintains the National Guidelines Clearinghouse.
- Evidence-based CPG's are a means of reducing clinical variability and improving clinical outcomes.
- Designed to improve safety, quality, and accessibility of healthcare.
- Specialty specific for all medical specialties:
- **https://www.guideline.gov/**

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Quality Payment Program and Medical Negligence Concerns: CPG's

- The role of CPG's:
  - Not yet considered a Standard of Care
  - May be used as evidence by medical experts in testimony
  - Rapidly increasing number of CPG's
  - Widely accepted use
  - Promoted by medical specialty societies, the National Institutes of Health, and Agency for Healthcare Research and Quality
  - Evidence based analysis supports the concept that reducing clinical variability can improve clinical outcomes in many cases.

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Quality Payment Program and Medical Negligence Concerns: Reputational Risk

- By 2019, all physicians may expect to see actual individual QPP 0-100 quality rating scores on public internet sites, such as Physician Compare.
- Physicians face reputational risk by not participating in QPP, or participating and earning low scores.
- Quality scores will become increasingly used by the public, and may become a quality reference in medical negligence suits.
- Physicians reporting in groups will have scores only as good as the group score.

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Physician Compare

- All Physicians enrolled with CMS have a Physician Compare web page.
- 900,000 physicians listed
- 140,000 hits/day
- Online quality reports on every physician
- CMS must allow reasonable opportunity to review results – may challenge
- 30 day annual preview period for all measurement data

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/Updating_and_Editing_Data_on_Physician_Compare.html

CMS Billing Data

- Billing data for all physicians is available to the public, on line from CMS.
- Provider name, gender, address
- NPI
- Medical Specialty
- HCPCS Code for Procedures Performed
- HCPCS Code Description
- Service Count
- Beneficiary Date Service Count (Number of procedures per Beneficiary)
- Medicare Allowed Amount
- Submitted Amount
- Medicare Paid Amount (Sum to determine totals)
- **Are you an unusual or high billing provider?**

Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicare-provider-charge-data/outpatient.html

Compliance and Quality of Care Investigation

Quality of Care Investigation

- St. Josephs' Medical Center, Baltimore, MD opens new, state of the art Cardiac Catheterization Laboratory in 2008.
- 1/2008: Retains leading NE area interventional cardiologist, Mark Midei, MD as Director.
- Cath Lab quickly becomes the "go to" facility for difficult cases and stent placement.
- Stent utilization exceeds all manufacturer's prior records, according to e-mail messages by manufacturer later discovered during investigation → over 1000 stents are placed in 2008.

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Quality of Care Investigation

- 11/08 & 4/09: In two letters, staff complain to the State Board of Physicians of 36 & 41 patients with "unnecessary stents."
- 4/09: Hospital employee who had a stent placed files a *qui tam* complaint with the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) complaining he/she received a stent that was not medically necessary. DHHS joins suit.
- 6/09: OIG begins a civil investigation.

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Quality of Care Investigation

- 4/09 to 6/09: 658 stent placements are reviewed as "not medically necessary."
- 4/09 to 6/09: Hospital relieves Dr. Midei, and eventually the CEO, CFO & other administrative staff.
- 10/09 to 2/10: Letters are sent advising patients to consult with their Cardiologist, because of unnecessary stents.
- Extensive advertising by the plaintiff's bar ensues, including Super Bowl ads.

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Quality of Care Investigation

- 2/10: Dr. Midei is the subject of a highly publicized U.S. Senate Finance Committee investigation.
- 11/10: Hospital settles the OIG's charges for $22M and enters a Corporate Integrity Agreement (CIA).
- 7/11: Dr. Midei's license to practice medicine is revoked by the State Board of Medicine on the basis of four medical records.
- Hundreds of medical malpractice lawsuits filed against Dr. Midei and the hospital.

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Quality of Care Investigation

- A media frenzy is ignited, with repetitive, negative news stories about Dr. Midei, the hospital, and parent company, Catholic Health Initiatives (CHI).
- 3/12: St. Josephs' Hospital announces sale to the University of Maryland Medical System. Patient utilization is at record lows. The Cath Lab is virtually closed.
- 2013: The first 21 "unnecessary stent" suits to reach court were consolidated into a single trial…. Rather than face future consolidated trials, defendants settled a group of over 200 cases for approximately $36M.

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Quality of Care Investigation

- 2014: Weinberg v. St. Joseph's Medical Center, Dr. Mark Midei. Plaintiff claims Mr. Weinberg quit his casino development job and lost $50M after stent placement.
- Phase I Trial: Jury deadlocked on negligence, eventually finds Dr. Midei guilty of medical negligence.
- Phase II Trial: Jury deadlocked on damages. Mistrial. Finding of negligence vacated with prejudice.
- Plaintiff's agreed prior to mistrial to accept a high/low arbitration of $500K to $15M. Mistrial payment: $500K.

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Quality of Care Investigation

- Remaining stent claims all settled without trial.
- Estimated total indemnity cost: $100 Million.
- Hospital almost closed, and was sold by its' parent company.
- Physician lost license.
- 658 patients were affected.
- Over 600 medical malpractice suits were filed.
- Could a quality audit have identified unusual utilization?

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Quality Payment Program and Medical Negligence Concerns: Administrative Burden

- QPP has a stated intent of reducing administrative burdens for clinicians.
- However, it is a significant program, requiring administrative attention to quality reporting measures, performance scores, and their effect on reimbursement.
- Physicians should be supported by strong administrators who understand and can implement the program, monitor results, and guide practices.

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Conclusions
Q&A

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QPP Service and Information Center

- Quality Payment Program Service Center
- 1-866-288-8292
- TTY: 1-877-715-6222
- Monday-Friday, 8 a.m. – 8 p.m., EST
- You may also subscribe to automatic e-mail updates at www.qpp.cms.gov
- Or, e-mail the QPP at **QPP@cms.hhs.gov**

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HEALTHCARE COMPLIANCE
and RISK MANAGEMENT?

Yes…we do that.