Health Care Compliance Association
Changing Payment Methodologies

October 6, 2017

Agenda

- Overview of CMS Quality Initiatives
- Closer Look at MIPS and APMs
- Proposed QPP Rule Year 2
- Compliance Risk and Strategies
- Resources
CMS Quality Initiatives

- Alternative Payment Models
- ESRD Quality Incentive Program
- Hospital-Acquired Condition Reduction Program
- Hospital Readmissions Reduction Program
- Merit-Based Incentive Payment System
- Value-Based Purchasing Programs
  - Home Health
  - Hospital
  - SNF

OIG Focus on Quality

- Work Plan
  - Medicare incentive payments for adopting EHR
  - ACO beneficiary assignment and MSSP payment
  - ACO savings, quality, and promising practices
  - Review of quality measures reported by MSSP ACOs
- OIG Reports
  - 2016 – Incorrect Medicaid EHR incentive payments to hospitals.
  - December 2016 – Early implementation review of CMS QPP
  - April 2017 - CMS validated IQR data/identify gaming
  - August 2017 – ACO reducing spending and improving quality under the MSSP
MACRA

- Medicare Access and CHIP Reauthorization Act of 2015
  - Repeals SGR
  - Replaced by Quality Payment Program
    - Merit-based Incentive Payment System (MIPS)
    - Advanced Alternative Payment Models (APM)
  - Effective January 1, 2017
  - Impacts revenues in 2019

Who can Participate?

- For 2017 and 2018 the following clinician types:
  - Physicians, which includes doctors of medicine, doctors of osteopathy (including osteopathic practitioners), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors;
  - Physician assistants;
  - Nurse practitioners;
  - Clinical nurse specialists;
  - Certified registered nurse anesthetists; and
  - Any clinician group that includes one of the professionals listed above
Who is Exempt?

- First year of Part B participation
- Medicare allowed charges ≤ $30k or ≤ 100
- Part B enrolled Medicare patients (groups assessed at the TIN level)
  - Part B /historical claims data from 9/1/15-8/31/16
  - 2nd determination on period 9/1/16-8/31/17
- Significantly participate in Advanced APM

Participation Options

- Providers can participate in MIPS as an:
  - Individual
  - Group
    - 2 or more clinicians who have reassigned billing to a single TIN
      - High performers or low performers may be positively or negatively affected by the group score
      - Assessed as group across all categories
      - Low volume thresholds apply at group level
  - Alternative Payment Model
Clinicians in Facilities

- 75% or more of clinician’s services provided in:
  - Inpatient hospital
  - On-campus outpatient hospital
  - Emergency room
- Subject to MIPS
- Report Quality and Improvement Activity
- Qualify for automatic reweighting of ACI unless ACI data is submitted

Not Subject to MIPS

- Clinicians billing under FQHC and RHC payment methodologies
- CAH Method I
Non-Patient Facing Clinicians

- An individual MIPS eligible clinician that bills 100 or fewer patient-facing encounters during the non-patient facing determination period, and
- A group provided that more than 75 percent of the clinicians billing under the group’s TIN meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period
- More flexible reporting requirements

MIPS®2017

- **Performance year**
  - March 31, 2018 Data Submission
  - Feedback
  - January 1, 2019 Payment Adjustment
  - CMS provides performance feedback after the data is submitted.
  - Clinicians will receive feedback before the start of the payment year

- **submit**

- **Feedback available**

- **adjustment**

- **2017 Performance Year**
  - Performance period opens January 1, 2017.
  - Clinicians care for patients and record data during the year
MIPS Potential Payment Adjustment

The potential maximum adjustment % will increase each year from 2019 to 2022.

MIPS Performance Categories

- Payments still based on the MPFS but can be adjusted either up or down depending on the provider’s Composite Performance Score (CPS).
- Four performance categories:
  - Quality – was PQRS
    - 60% of final score
  - Cost – was VM
    - 0% in 2017
  - Advancing Care Information (ACI) – was EHR
    - 25% of final score
  - Improvement Activities (IA)
    - 15% of final score
Pick Your Pace

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017
- Submit some data after January 1, 2017
- Neutral or small payment adjustment
- Submit a Partial Year

MIPS
- Report for 90-day period after January 1, 2017
- Small positive payment adjustment
- Submit a Full Year

Full Year
- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.

Quality

- Select 6 of about 300 quality measures or 1 specialty set (minimum of 90 days to be eligible for maximum payment adjustment);
- 1 must be:
  - Outcome measure OR
  - High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

https://qpp.cms.gov/mips/quality-measures
Cost Category – 0%

- No reporting requirement
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on performance in the category in 2017, but it will not affect 2019 payments
- Quality Resource Use Report (QRUR)

Advancing Care Information - 25%

<table>
<thead>
<tr>
<th>BASE SCORE</th>
<th>PERFORMANCE SCORE</th>
<th>BONUS SCORE</th>
<th>FINAL SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account for</td>
<td>Account for up to</td>
<td>Account for up to</td>
<td>Earn 100 or more</td>
</tr>
<tr>
<td>of the total</td>
<td>of the total</td>
<td>of the total</td>
<td>percent and receive</td>
</tr>
<tr>
<td>Advancing Care</td>
<td>Advancing Care</td>
<td>Advancing Care</td>
<td>FULL 25</td>
</tr>
<tr>
<td>Information</td>
<td>Information</td>
<td>Information</td>
<td>points</td>
</tr>
<tr>
<td>Performance</td>
<td>Performance</td>
<td>Performance</td>
<td>of the total</td>
</tr>
<tr>
<td>Category Score</td>
<td>Category Score</td>
<td>Category Score</td>
<td>Advancing Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Performance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Category Final Score</td>
</tr>
</tbody>
</table>

The overall Advancing Care Information score would be made up of a base score, a performance score, and a bonus score for a maximum score of 100 percentage points.
### Advancing Care Information (ACI) Base Score - 50%

<table>
<thead>
<tr>
<th>Advancing Care Information Objectives and Measures (2015)</th>
<th>2017 Advancing Care Information Transition O&amp;M (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Security Risk Analysis</td>
<td>[ ] Security Risk Analysis</td>
</tr>
<tr>
<td>[ ] E-Prescribing</td>
<td>[ ] E-Prescribing</td>
</tr>
<tr>
<td>[ ] Provide Patient Access</td>
<td>[ ] Provide Patient Access</td>
</tr>
<tr>
<td>[ ] Send a Summary of Care</td>
<td>[ ] Health Information Exchange</td>
</tr>
<tr>
<td>[ ] Request/Accept a Summary of Care</td>
<td></td>
</tr>
</tbody>
</table>

- [https://chpl.healthit.gov/#/search](https://chpl.healthit.gov/#/search)

(2015 certified EHR)

### ACI Performance Measures – 90%

<table>
<thead>
<tr>
<th>ACI Objective and Measures Performance – up to 10 points each</th>
<th>2017 ACI transition O&amp;M – up to 10 points except where indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Patient access*</td>
<td>[ ] Patient access* – 20 points</td>
</tr>
<tr>
<td>[ ] Patient-specific education</td>
<td>[ ] Health Information exchange* – 20 points</td>
</tr>
<tr>
<td>[ ] View, download and transmit</td>
<td>[ ] View, download and transmit</td>
</tr>
<tr>
<td>[ ] Secure messaging</td>
<td>[ ] Patient-specific education</td>
</tr>
<tr>
<td>[ ] Patient-generated health data</td>
<td>[ ] Secure messaging</td>
</tr>
<tr>
<td>[ ] Send a summary of care*</td>
<td>[ ] Medication reconciliation</td>
</tr>
<tr>
<td>[ ] Req/accept summary of care*</td>
<td>[ ] Immunization registry reporting</td>
</tr>
<tr>
<td>[ ] Clinical info reconciliation</td>
<td></td>
</tr>
<tr>
<td>[ ] Immunization registry reporting</td>
<td></td>
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</tbody>
</table>

|                                                            | [ ] Immunization registry reporting                          |
|                                                            |                                                            |

* Baseline measures as well
ACI Bonus Score – 15%

- 5% bonus for reporting one or more of the following:
  - Syndromic surveillance reporting (14 & 15)
  - Specialized registry reporting (14)
  - Electronic case reporting (15)
  - Public Health Registry (15)
  - Clinical Data Registry (15)
- 10% bonus for using CEHRT to report certain Improvement Activities

ACI Flexibility

CMS automatically reweight ACI category to quality for:
- Hospital based clinicians
- Non-facing clinicians
- NP, PA, CRNAs and CNS
- Apply and approved for significant hardship
Improvement Activities 15% of Score

- Activity weights
  - Medium = 10 points
  - High = 20 points
- Total points = 40 Maximum
- Full credit for clinicians in a patient-centered medical home, medical home model, or similar specialty practice

https://qpp.cms.gov/mips/improvement-activities

Improvement Activities Special Rules

- 15 or fewer clinicians and solo practitioners
- Rural areas
- HPSA
  - Doubled points for both medium and high-weight activities:
    - Medium = 20 points
    - High = 40 points
## Transition Year 2017

<table>
<thead>
<tr>
<th>Final CPS</th>
<th>Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 70 points</td>
<td>Eligible for exceptional performance bonus-minimum of additional 0.5%</td>
</tr>
<tr>
<td>4-69 points</td>
<td>Positive adjustment</td>
</tr>
<tr>
<td>3 points</td>
<td>Neutral payment adjustment</td>
</tr>
<tr>
<td>0 points</td>
<td>Negative payment adjustment of 4%</td>
</tr>
</tbody>
</table>

## MIPS Data Validation

- CMS performs annual MIPS data validation
- Request for audit requires 10 day response
- Quality – claims and registry submissions
  - Fewer than 6 measures, or
  - No outcome or high priority measure, or
  - Report less than full set of specialty measures
MIPS Data Validation

- ACI performance category and Improvement Activities
  - MIPS Data Validation Criteria 2017
    https://qpp.cms.gov/about/resource-library
- Retain documentation
  - 6 years MIPS
  - 10 years FCA

MIPS Proposed 2018 Changes

- Continue Pick Your Pace option
- Increase low-volume threshold - ≤ $90,000 in Part B allowed charges or ≤ 200 beneficiaries
- Opt-in to MIPS if exceed 1 OR 2 of the low volume thresholds
- Virtual groups – composed of solo practitioners and groups of 10 or fewer
- Facility based measurement based on hospital value based purchasing program
MIPS Proposed 2018 Changes, Cont.

- **Quality component changes:**
  - Weight 60% in 2020 payment year, 30% in 2021 and beyond
  - Except for Web interface and CAHPS, increase data completeness threshold to 60% for 2019 performance period
  - 1 point instead of 3 if data completeness not met unless a small practice
  - Reward performance improvement compared to prior performance period – category measure

MIPS Proposed 2018 Changes, Cont.

- Increase number of providers in a group who need to complete IA
- Allow 2014 or 2015 edition CEHRT with a bonus for using 2015
- Add a decertified exception
- New hardship exception for small practices to reweight ACI to the quality category (85%)
MIPS Proposed 2018 Changes

- Cost weighted at zero and go to 30% in 2020
- Three bonus points for complex patients
- Five bonus points for small practices
- Change performance threshold from 3 to 15
- Twelve month performance period for quality and cost and 90 day minimum for ACI and IA
- Allow multiple submission methods for measures and activities

Participation in Alternative Payment Models (APM)

<table>
<thead>
<tr>
<th>Potential financial rewards</th>
<th>Not in APM</th>
<th>In APM</th>
<th>In Advanced APM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MIPS adjustments</td>
<td>MIPS adjustments</td>
<td>APM-specific rewards</td>
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<tr>
<td>If you are a Qualifying APM Participant (QI)</td>
<td></td>
<td></td>
<td>5% lump sum bonus</td>
</tr>
</tbody>
</table>

If you are a Qualifying APM Participant (QI)
Advanced Alternative Payment Models

- Requirements:
  - Use certified EHR technology
  - Quality measures comparable to MIPS
  - Bear more than nominal financial risk, OR
  - Medical Home Model expanded by the CMS Innovation Center
- Earn APM rewards plus a 5% lump sum bonus based on the QP’s estimated aggregate Medicare payment amounts for the preceding year

APM Qualifying Participants (QP)

- Received 25% of Medicare payments, OR
- 20% of their Medicare patients
  - 5% bonus from CMS
  - No MIPS reporting
- Partial QP – 20% payments, OR 10% patients
  - Opt Out – no positive or negative adjustment
  - Opt In – Report MIPS
- Determination dates
  - March 31
  - June 30
  - August 31
2017 Advanced APMs

- Comprehensive ESRD Care Model
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Saving Program ACOs Tracks 2, and 3
- Next Generation ACO Model
- Oncology Care Model (2 sided risk)


APMs Proposed 2018 Changes

- Extend the revenue-based nominal standard amount for 2 more years
- Change the nominal amount standard for Medical Home Models
- All-payer combination option allows eligible providers to become QPs
MACRA Compliance Risk Areas

- Integrity of clinical quality data
- Accurate clinical documentation to support quality measures
- Accuracy of attestations
- MIPS rules are evolving and complex
- Fraud and Abuse Waivers
- Avoidance of at-risk patients
- Compliance with ACO requirements
- HIPAA violations
- Physician contracting

Compliance Risk Related to EHR

- EHR adoption
- Scribes
- Audit trails
- Downtime procedures
- Not understanding the full functionalities that exist to document, capture and report quality
- Misuse of EHR
  - Copy/paste
  - Cloning
Compliance Strategies

- Know which track your providers are on and understand the rules
- Establish a MIPS and/or APM education for providers and staff
- Make sure providers, coders and staff understand the requirements for the selected quality measures
- Update compliance policy and code of conduct
- Compliance should have a seat on the organization’s quality team
- Oversight and reporting to the Board
- Update your compliance plan to include monitoring and validation of quality measures, Improvement Activities and Advancing Care Information

Compliance Strategies Cont.

- Conduct a risk assessment to understand and evaluate how quality data is collected and reported:
  - Accuracy and completeness of quality data
  - Content and completion of training for staff and providers
  - ICD10 and HCC coding education for professional coders
  - Who has oversight for the process?
  - What monitoring is in place?
  - How are errors identified, reported and corrected?
  - Who will sign the attestations?
Resources

- Specialty Societies
- https://www.healthit.gov/providers-professionals
- https://qpp.cms.gov/about/resource-library

QUESTIONS?

Karen A. Robinson. CPC, CHC
Manager – Health Care Services
voice: 800.642.3601 ext. 3702
Karen.Robinson@actcpas.com