

**Arnett  
Carbis  
Toothman LLP**  
CPAs & Advisors

**Health Care Compliance Association  
Changing Payment Methodologies**

ACT October 6, 2017

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### Agenda

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

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### 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

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## 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




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## 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




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## 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




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### Who is Exempt?

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



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### 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



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### 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



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### Not Subject to MIPS

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



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### 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



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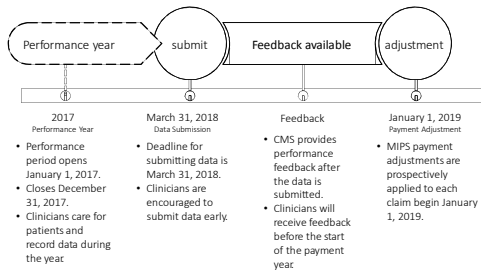
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### MIPS 2017



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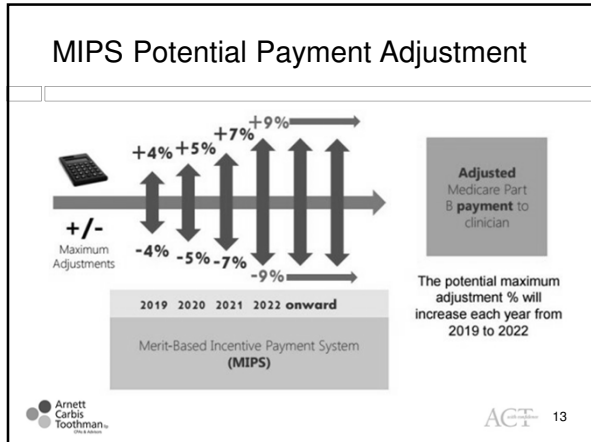
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- ### MIPS Performance Categories
- Payments still based on the MPFS but can be adjusted either up or down depending on the provider's Composite Performance Score (CPS).
  - Four performance categories:
    - Quality – was PQRS
      - 60% of final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

Participate in an Advanced Alternative Payment Model	Test Pace	MIPS Partial Year	MIPS Full Year
<ul style="list-style-type: none"> <li>• Some practices may choose to participate in an Advanced Alternative Payment Model in 2017</li> </ul>	<ul style="list-style-type: none"> <li>• Submit <b>some</b> data after January 1, 2017</li> <li>• Neutral or small payment adjustment</li> </ul>	<ul style="list-style-type: none"> <li>• Report for 90-day period after January 1, 2017</li> <li>• Small positive payment adjustment</li> </ul>	<ul style="list-style-type: none"> <li>• Fully participate starting January 1, 2017</li> <li>• Modest positive payment adjustment</li> </ul>

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

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## Quality

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- 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>

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## Cost Category – 0%

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- 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)

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## Quality Payment Program Advancing Care Information- 25%

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<b>BASE SCORE</b>	<b>+</b>	<b>PERFORMANCE SCORE</b>	<b>+</b>	<b>BONUS SCORE</b>	<b>=</b>	<b>FINAL SCORE</b>
Account for		Account for up to		Account for up to		Earn 100 or more percent and receive
of the total Advancing Care Information Performance Category Score		of the total Advancing Care Information Performance Category Score		of the total Advancing Care Information Performance Category Score		<b>FULL 25 points</b> of the total Advancing Care Information Performance Category Final Score

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

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### Advancing Care Information (ACI) Base Score - 50%

<b>Advancing Care Information Objectives and Measures (2015)</b>	<b>2017 Advancing Care Information Transition O&amp;M (2014)</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Security Risk Analysis</li> <li><input type="checkbox"/> E-Prescribing</li> <li><input type="checkbox"/> Provide Patient Access</li> <li><input type="checkbox"/> Send a Summary of Care</li> <li><input type="checkbox"/> Request/Accept a Summary of Care</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Security Risk Analysis</li> <li><input type="checkbox"/> E-Prescribing</li> <li><input type="checkbox"/> Provide Patient Access</li> <li><input type="checkbox"/> Health Information Exchange</li> </ul> <p><a href="https://www.healthit.gov/providers-professionals/security-risk-assessment-tool">https://www.healthit.gov/providers-professionals/security-risk-assessment-tool</a></p> <p><a href="https://chpl.healthit.gov/#/search">https://chpl.healthit.gov/#/search</a> (certified EHR)</p>

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### ACI Performance Measures – 90%

<b>ACI Objective and Measures Performance – up to 10 points each</b>	<b>2017 ACI transition O&amp;M – up to 10 points except where indicated</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Patient access*</li> <li><input type="checkbox"/> Patient-specific education</li> <li><input type="checkbox"/> View, download and transmit</li> <li><input type="checkbox"/> Secure messaging</li> <li><input type="checkbox"/> Patient-generated health data</li> <li><input type="checkbox"/> Send a summary of care*</li> <li><input type="checkbox"/> Req/accept summary of care*</li> <li><input type="checkbox"/> Clinical info reconciliation</li> <li><input type="checkbox"/> Immunization registry reporting</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Patient access* – 20 points</li> <li><input type="checkbox"/> Health Information exchange* – 20 points</li> <li><input type="checkbox"/> View, download and transmit</li> <li><input type="checkbox"/> Patient-specific education</li> <li><input type="checkbox"/> Secure messaging</li> <li><input type="checkbox"/> Medication reconciliation</li> <li><input type="checkbox"/> Immunization registry reporting</li> </ul> <p>* Baseline measures as well</p>

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### 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

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### 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
  - Exception Form:  
[https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj\\_Hardship.html](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html)



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### 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>



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### 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



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### Transition Year 2017

Final CPS	Payment Adjustment
≥ 70 points	Eligible for exceptional performance bonus-minimum of additional 0.5%
4-69 points	Positive adjustment
3 points	Neutral payment adjustment
0 points	Negative payment adjustment of 4%

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### 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

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### 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

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### 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



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### 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



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### 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%)



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### 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




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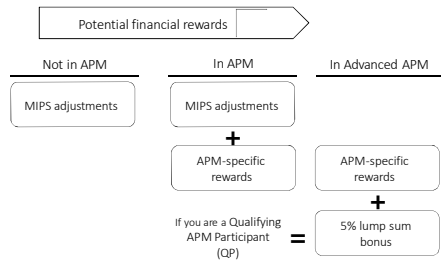
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### Participation in Alternative Payment Models (APM)




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### 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




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### 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



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### 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)
- [https://qpp.cms.gov/docs/QPP\\_Advanced\\_APMs\\_in\\_2017.pdf](https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf)



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### 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



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### 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



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### 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



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### 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



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### 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?



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### Resources

- Specialty Societies
- <https://www.healthit.gov/providers-professionals>
- <https://qpp.cms.gov/about/resource-library>
- [https://qpp.cms.gov/docs/QPP\\_Support\\_for\\_Small\\_Practices.pdf](https://qpp.cms.gov/docs/QPP_Support_for_Small_Practices.pdf)
- [https://qpp.cms.gov/docs/QPP\\_Technical\\_Assistance\\_Resource\\_Guide.pdf](https://qpp.cms.gov/docs/QPP_Technical_Assistance_Resource_Guide.pdf)
- <http://www.qualityinsights-gin.org/Initiatives/MACRA-MIPS.aspx>



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### QUESTIONS?

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