MEDICARE AND VALUE-BASED PAYMENT

- For more than two decades, "traditional" fee-for-service Medicare has been shifting towards value-based payment
- An alphabet soup of programs:
  - For hospitals: Hospital Inpatient and Outpatient Quality Reporting; Hospital Value-Based Purchasing; Hospital Compare, CMS Innovation Center "alternative payment models"
  - For clinicians: Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBM), Physician Compare
- MACRA and the Medicare Quality Payment Program mark a significant step towards tying payment for clinicians' professional services to quality and value

THE CHALLENGES

- Incompatible Record Systems
- Rising Costs, Mixed Outcomes
- Lack of Transparency
- Fraud, Waste and Abuse
- Moral Hazard / Adverse Selection
- Undesirable Variation
- Risk Adjustment
- Perverse Incentives
- Inconsistent Quality Metrics
- Social Risk Factors
- Defensive Medicine
- Silos / Lack of Care Coordination
- Drug Costs
- Technology Costs
- Primary Care Shortages

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

The Medicare Quality Payment Program and Compliance Oversight
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MEDICARE AND VALUE-BASED PAYMENT
MEDICARE FOR ALL?
- A recent Commonwealth Fund study found that 27% of Medicare beneficiaries spend 20% or more of their income on premiums, cost sharing, and uncovered services.
- No out of pocket cap
- Omits benefits for
  - Dental
  - Vision
  - “Custodial” care
  - Disease management / health promotion
- Limited coverage for
  - Dentures
  - Case management / care coordination

THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)
- Repealed the Medicare sustainable growth rate (SGR)
- Replaced SGR with a value-based approach to payment for Medicare covered professional services provided to fee-for-service beneficiaries
- Sunsets existing Medicare quality reporting programs and Medicare Electronic Health Record Incentive Program (aka the “Meaningful Use” Program)
- Streamlined and combined existing quality and EHR incentive programs into a single “Quality Payment Program”
- Added incentives to encourage participation in “alternative payment models” that include shared financial risk

HISTORICAL CONTEXT – PHYSICIAN PAYMENT
QUALITY PAYMENT PROGRAM

Two alternative tracks:

• The Merit-Based Incentive Payment System (MIPS)
• Advanced Alternative Payment Models (APMs)

Applies to Medicare FFS program only

Eligible clinicians include physicians, NPs, PAs, CNS and CRNAs

Exemptions:

• Clinicians in their first year of participation in Medicare Part B
• Clinicians who treat a low volume of Medicare FFS patients receive a low volume of Medicare Part B reimbursement

Clinicians can participate as individuals, as part of a group practice, or starting in 2018, as part of a “virtual group”

MACRA TIMELINE

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

• Adjust Medicare FFS reimbursement +/-/neutral based on composite performance score (out of 100 points) compared to other clinicians/groups
• Composite performance score based on weighted performance in four categories
  • Quality
  • Cost / Resource Use
  • Clinical Practice Improvement Activities
  • Advancing Care Information
• Two year lag between performance and payment adjustment– e.g., performance in 2018 affects Medicare FFS payment in 2020
• Zero-sum game; winners and losers
MIPS: QUALITY

- Clinical quality measures and technical specifications published annually, similar to Physician Quality Reporting System
- Focus on clinical process and patient health outcomes measures
- Most clinicians/groups required to report 6 measures, including 1 outcome measure
  - Exceptions: Groups reporting via CMS Web Interface
- Groups of 16 or more also scored on all-cause hospital readmissions
- Each measure scored between 0 and 10 points, depending on data completeness and performance relative to published benchmarks
  - "Bonus" points for certain "high priority" measures and electronic submission (capped)
- Additional points for improvement compared to previous year (category level)
- Worth 60% of composite score for Year 1; 50% of score for Year 2; 30% for Year 3

MIPS: COST (RESOURCE USE)

- For Year 1, CMS will provide feedback on cost measures for information only
- Worth 0% of composite score in Year 1; 10% in Year 2; 30% in Year 3
- Score based on two claims-based measures established by CMS (no reporting required):
  - Total Per Capita Costs for all attributed Medicare beneficiaries
  - Medicare Spending per Beneficiary
- 10 episode-based measures adopted for 2017 have been withdrawn; CMS is in the process of developing new episode-based measures for 2018
- Additional points for improvement compared to previous year (measure level) – capped at 1 percent for Year 2

MIPS: ADVANCING CARE INFORMATION

- Performance score is the sum of:
  - Base score – based on reporting of required set of measures related to the use of certified EHR technology (CEHRT)
  - Performance score – based on clinician’s “performance rate” on certain measures (i.e., a percentage of patient encounters in which the clinician performs a specified activity)
  - Bonus score – based on completing additional public health and registry reporting activities using CEHRT or performing “improvement activities” using CEHRT
- Additional bonus points available for using 2015 Edition only
- Worth 25% of composite performance score
**MIPS: CLINICAL PRACTICE IMPROVEMENT ACTIVITIES**

- Inventory of nearly 100 activities in 9 subcategories; published annually on Medicare Quality Payment Program website
- Each activity worth a certain number of points
  - Giving patients access to their medical records online through an enhanced patient portal that includes interactive features and/or the ability to communicate with the practice about managing their health (medium)
  - Offering integrated behavioral health services with primary care (high)
- Clinicians may select improvement activities appropriate for their practice and must attest to performance during performance period
- Worth 15% of composite performance score

**ALTERNATE REQUIREMENTS AND SCORING**

- Non-patient facing clinicians (e.g., anesthesiologists, pathologists, radiologists)
- Clinicians in small practices (fewer than 15 clinicians)
- Practices located in rural and health professional shortage areas
- Clinicians/groups participating in Advanced APMs but who do not meet the participation thresholds to be “Qualifying APM Participants”

**PUBLIC REPORTING AND COMPLIANCE**

- Information related to MIPS performance will be published on the Physician Compare website
- CMS will selectively audit clinicians on a yearly basis and may request primary source documents
CHANGES FOR QUALITY PAYMENT PROGRAM YEAR 2

- Increase MIPS performance threshold to 15 points (out of 100)
- Cost performance category assigned weight of 10%, quality performance category weighted at 50%
- Bonus points:
  - For using only 2015 CEHRT
  - For treatment of complex patients: up to 5 points
  - For clinicians in small practices (15 or fewer clinicians): up to 5 points
- Adding “virtual groups” for solo practitioners and small group practices
- Clinicians have option to continue to use 2014 CEHRT, use 2015 CEHRT, or both
- Increased low-volume threshold to exclude MIPS eligible clinicians or groups with <= $90,000 in Part B allowed charges or <= 200 Medicare Part B beneficiaries
- Additional flexibility for small independent practices

ADVANCED ALTERNATIVE PAYMENT MODELS (APMS)

- Require providers to take on “more than nominal” risk or be a medical home model
- APM revenue threshold starts at 25% in the first performance year and increase to 75%
- Not every APM will qualify for incentive payment from CMS, but some commercial APMS may count (2021 on)
- 2019 – 2024: 5% incentive payment for participation that meets a revenue threshold
- 2026: larger fee schedule increases for APM participants (0.75% versus 0.25% annual increase to base)

ADVANCED APM CRITERIA

- Use Certified EHR technology
- Link payment with quality measures comparable to those used in MIPS
- Accept more than nominal risk (8%) or follow the Patient-Centered Medical Home model
- Meet volume/financial thresholds
- Types:
  - Medicare ACO Track 1+
  - Next Generation ACOs
  - Comprehensive Primary Care Plus (CPC+)
  - Comprehensive Care for Joint Replacement (CJR) model
  - Oncology Care Model
  - Comprehensive ESRD Care Model
PATIENT-CENTERED MEDICAL HOME MODELS

- Primary care practices and multispecialty groups that offer primary care
- Each patient is on a primary clinician’s panel
- At least 4 of the following:
  - Coordinated chronic and preventive care
  - Patient access and continuity of care
  - Risk-stratified care management
  - Coordination of care across the “medical neighborhood”
  - Patient and caregiver engagement
  - Shared decision-making
  - Payment arrangements other than FFS alone (such as monthly care coordination fees)

ADVANCED APM PARTICIPANTS

- Qualifying APM participants (QPs)
- 5% incentive payment from 2019 through 2024
- Excluded from MIPS reporting and payment adjustments
- CMS expects 185,000 to 200,000 QPs to participate in 2018 (for payment year 2020)
- CMS identifies QPs via APM participant lists + beneficiary attribution data + claims data
- For 2018, QPs must see at least 20% of their patients or receive 25% of their Medicare payments through an Advanced APM to qualify
- Increases in later years up to 50% of patients / 75% of payments, but also includes Medicaid and commercial payer APMs

KEY COMPLIANCE CONCERNS

- Do we need to reevaluate what is fair market value when physicians are being paid for value under a variety of complex payment methodologies?
- How can larger health systems assist community physicians without running into Stark law issues?
- Could noncompliance with quality reporting specifications lead to False Claims Act risk?
- Will the same Risk Adjustment Factor (RAF) coding concerns that have challenged Medicare Advantage plans also lead to new coding risks for physicians?
- Could MIPS cost measures and APM targets lead to stinting on patient care and possible exposure to Civil Money Penalties?
- Will physicians who take on risk in Advanced APMs need state insurance licenses?
QUALITY REPORTING AND THE FCA — CASE STUDY

- CMS’s Hospital Value-Based Purchasing program adjusts payments based on a hospital’s overall performance on 21 quality measures.
- One measure was door to EKG for patients who presented to the ED with chest pain (c. 2010 – 2013).
- CMS’s measure specifications define “arrival time” as “The earliest documented time the patient arrived” at the hospital.
- In an effort to improve its scores, a Midwestern hospital implemented a practice of doing EKGs before completing the registration process in its EHR.
- When patients arrived at the ED, triage nurses would record basic information about each patient on a paper form, which they discarded after they completed a more detailed EHR triage note once the patient was formally registered.

QUALITY/FCA CASE STUDY

- The ED director told the triage nurses to report triage time in their final EHR notes as the same time as the EKG. The hospital used the times recorded in the EHR to report its quality data.
- Make sure those patients who present to triage with chest pain come STRAIGHT BACK TO A ROOM – NO VS IN triage – StraightBack, Jack!! Quick registration can be done at bedside!! Bare the chest FIRST – get those patches on and get the EKG done. Then finish uncovering the pt., put on O2, put on monitor, get VS, etc. Door to EKG is 3 minutes!! Why do this, but it will require a change in current practice.
- Yes, we are looking at other creative ways to expedite our processes to meet the “3 minute goal.” The key factor here will be when we complete the registration process, so when in doubt wait to register until that 12 lead is completed.
- Between 2010 and 2011, the hospital’s median door to EKG time went from 9.3 minutes to 0 minutes.

CODING AND RISK ADJUSTMENT

- MIPS uses the same Hierarchical Condition Code (HCC) / Risk Adjustment Factor (RAF) system as Medicare Advantage to account for patient acuity.
- Physicians are not accustomed to having ICD-10-CM codes affect their payments.
- Should physician practices develop an ambulatory query process, like hospitals have for inpatient clinical documentation improvement activities?
- Is there an obligation to “look both ways” when auditing charts for potential missed HCCs?
- UnitedHealthCare and the DOJ have been involved in litigation where whistleblowers alleged that UHC designed audits to add HCCs that were missed, but not to verify that previously reported HCCs were actually supported by documentation.
STARK AND ANTI-KICKBACK COMPLIANCE

- Value-based payment may change market trends for compensation for physicians’ professional and administrative services
  - Fair Market Value of compensation
  - Commercial Reasonableness of terms in light of changes to Medicare reimbursement
- Growing interest in pay for performance arrangements that use quality incentives to align hospital and physician financial interests with value of referrals of federal health care program business
  - Unless a waiver is available, as in the Medicare Shared Savings Program ACOs and the Comprehensive Care for Joint Replacement bundled payment model

STARK AND ANTI-KICKBACK COMPLIANCE

- Hospitals and physicians may have increased interest in sharing access to electronic health records (EHR) technology and other technology items and services
  - Consider Stark exception, Anti-Kickback Statute safe harbor and IRS guidance related to EHR donation programs
- Community physicians may be looking to other health care organizations for help understanding and implementing Medicare Quality Payment Program requirements
  - Evaluate support services for risks under False Claims Act, Stark Law and Anti-Kickback Statute
  - Consider HIPAA and HITECH requirements for participating in a Health Information Exchange

OTHER POTENTIAL PITFALLS

- Civil Money Penalties Law risks
  - Incentives to stint on care
  - Beneficiary inducement potential with creative non-covered services to keep patients healthier and out of the hospital (if no waiver applies)
- Physician who accept financial risk and state insurance laws
- The “free ride” problem: How do Virtual Groups and APMs structure themselves so that all participants are accountable yet independent?
**MACRA CHALLENGES**

- Complexity, especially for smaller practices
- Reporting by Tax ID can be a challenge for multispecialty groups – not all measures fit all clinicians' practices
- Limited ability to manage risk in a small population
- Incentives are delayed in time and relatively small
- Budget neutrality makes it a zero-sum game
- Growing number of physicians will be exempt; others may exit Medicare, increasing competition for those who remain
- Subject to the same risk adjustment challenges and legal risks as MA with the RAF/HCC system

**RESOURCES**

- National Quality Forum measures: [www.qualityforum.org/QPS](http://www.qualityforum.org/QPS)
- CMS Value-Based Programs: [www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html)
- Patient-Centered Medical Home resources: [http://punch.ahrq.gov/page/defining-pcmh](http://punch.ahrq.gov/page/defining-pcmh)