PAY FOR PERFORMANCE COMPLIANCE PITFALLS AND OPPORTUNITIES

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WHAT IS PAY FOR PERFORMANCE NOW AND HOW HAS IT CHANGED?

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HISTORY

- For decades, health care was reimbursed using a fee-for-service model → providers rewarded for volume
  - Concern: high costs
- During the 1990s, payers focused on managed care programs to reduce excessive or unnecessary care → limiting access to providers via networks, capitated reimbursement
  - Concern: compromised quality and constraints on patient choice of provider
- Quality concerns led to emergence of P4P → focus on quality with expectation that doing so would reduce costs

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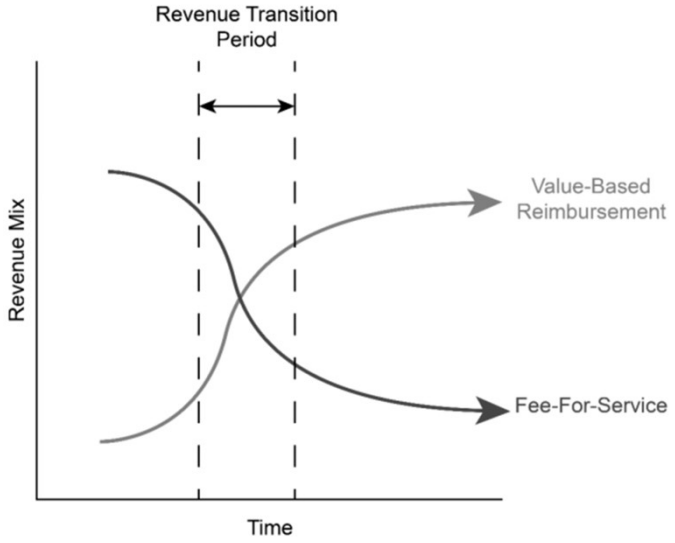
SHIFT IN PAYMENT FROM VOLUME TO VALUE



Source: http://sheridanhealthcare.com/news-events/blog/how-to-manage-the-burdens-of-change-on-physicians-and-health-care-practitio

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TYPICAL P4P PROGRAM

- Provides a bonus to health care providers if they meet or exceed agreed-upon quality or performance measures
  - Example: Reducing A1C in diabetic patients
- May also reward performance over time
  - Example: Year-to-year decreases in avoidable hospital readmissions
- May also impose financial penalties on providers that fail to achieve specific goals or cost savings
  - Example: No reimbursement for preventable conditions (e.g., bed sores) during hospital stay

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TYPICAL QUALITY MEASURES

- **Process** measures assess the performance of activities that contribute to positive health outcomes for patients
- **Outcome** measures refers to the effects that care had on patients
- **Patient experience** measures assess patients' perceptions of quality of care received and satisfaction with their care experience
- **Structure** measures relate to the facilities, personnel, and equipment used in treatment

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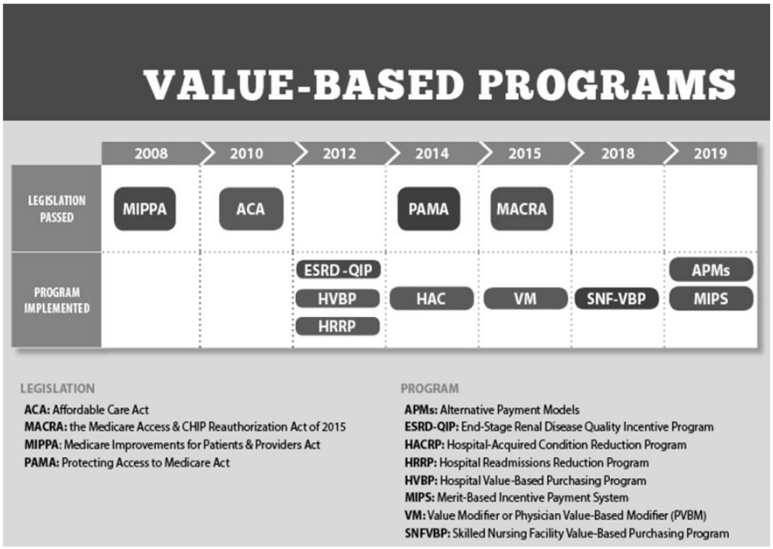
FEDERAL VALUE-BASED PROGRAMS



Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

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IMPORTANT LEGISLATION

- The Affordable Care Act (ACA)
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Medicare Improvements for Patients and Providers Act (MIPPA)
- Protecting Access to Medicare Act (PAMA)

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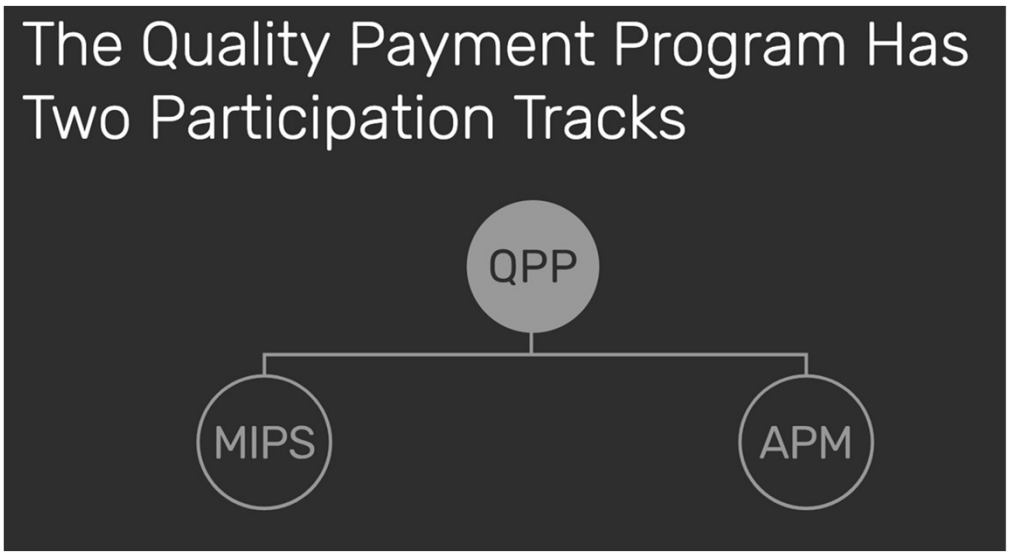

Source: https://qpp.cms.gov/about/qpp-overview

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MERIT-BASED INCENTIVES PAYMENTS (MIPS)

- Adjusts payment based on performance in four categories:
  - Quality – based on the Physician Quality Reporting System (PQRS)
  - Cost – based on the Value-based Payment Modifier (VBPM)
  - Promoting Interoperability (PI) – based on the Medicare EHR Incentive Program (Meaningful Use)
  - Improvement activities – a new category

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MIPS: PERFORMANCE CATEGORIES

- Performance categories carry different weights that will shift as the program progresses.

PERFORMANCE PERIODS			
Performance Category	2019	2020	2021
Quality	45%	40%**	35%**
Cost	15%	20%**	25%**
Promoting Interoperability	25%*	25%*	25%*
Improvement Activities	15%	15%	15%

*If the Secretary of the U.S. Department of Health and Human Services (HHS) determines the proportion of eligible clinicians who are "meaningful users of electronic health records (EHRs)" is estimated at 75% or greater, the weight of the PI category may be reduced. The remaining performance categories will be increased by the corresponding number of percentage points. The lowest weight the PI category can carry is 15%.

**Anticipated category weights

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Source: https://www.aafp.org/practice-management/payment/medicare-payment/mips.html

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MIPS: PAYMENT ADJUSTMENTS

- Payment adjustments, based on the final score, are based on performance from two years prior (e.g., performance in 2019 determines payment adjustments in 2021).
- Adjustments are made on the following sliding scale:

PERFORMANCE YEAR	PAYMENT YEAR	POTENTIAL POSITIVE/NEGATIVE PAYMENT ADJUSTMENT
2018	2020	±5%
2019	2021	±7%
2020	2022	±9%
2021	2023	±9%

Source: https://www.aafp.org/practice-management/payment/medicare-payment/mips.html

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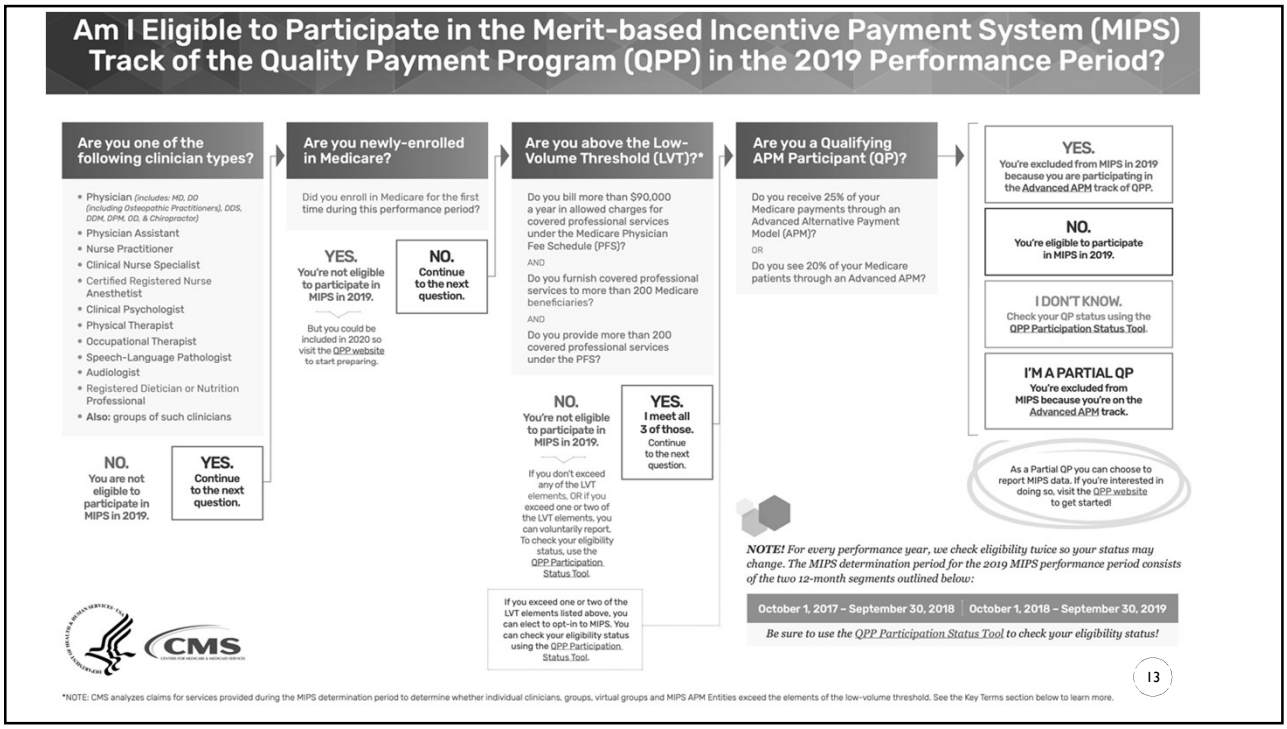

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ALTERNATIVE PAYMENT MODELS (APMS)

- APMs are systems of care and models for payment specifically designed to deliver value-based care by rewarding high-quality, low-cost care.
- APMs include, among other models, accountable care organizations (ACOs), patient-centered medical homes, and bundled payment models for specific conditions and procedures.
- APMs can apply to a specific clinical condition, a care episode, or a population

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ADVANCED APMS (AAPMS)

- Requires participants to use certified EHR technology;
- Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and
- Is either a Medical Home Model expanded under CMS Innovation Center authority OR requires participants to bear a significant financial risk.
- Potential Benefits?
  - 5% bonus
  - APM-specific rewards
  - Exclusion from MIPS

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QUALIFYING AAPM PARTICIPANT (QP) IN 2019

- To become a QP, you must receive at least 50% of your Medicare Part B payments or see at least 35% of Medicare patients through an Advanced APM entity at one of the determination periods (i.e., snapshots)
- Plus, 75% of practices need to be using certified EHR Technology within the AAPM entity.
  - An APM entity is an group (TIN) that has billing rights of a participant or participants (NPIs) that participates in an APM or payment arrangement with a non-Medicare payer through a direct agreement or through Federal or State law or regulation.

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PROVIDER VALUE BASED MODIFIER (PVBM)

- As with other value based systems, looks at quality and cost of care
- Adjustment will be made on a per-claim basis for Medicare payments under the Medicare Physician Fee Schedule (MPFS)
- Applied at the Taxpayer Identification Number (TIN) level
  - If bill individually, at the physicians TIN level
  - If bill under a group practice, at the practice level TIN

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PROVIDER VALUE-BASED MODIFIER (PVBM)

- Definitions
  - Eligible Professional (EP)
    - Physician – MD, DO, DPM, Doctor of Optometry, Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Chiropractic
    - Practitioner – Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (Anesthesiologist Assistant), Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologist
    - Therapist – Physical therapist, Occupational Therapist, Qualified Speech Language Therapist

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PROVIDER VALUE BASED MODIFIER

- All providers subject the value based modifier as of 2018
- Value modifier is not a modifier added to a code when billing
  - It is a system whereby Medicare makes adjustments to reimbursement based on:
    - Quality of care
    - Cost of care
- First performance period where data gathered – 2013
- Application of modifier began in 2015 for physicians in groups of 100 or more Eligible Professionals

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PROVIDER VALUE BASED MODIFIER

- Physicians in groups with 10 or more Eligible Professionals
  - Performance measurement year – 2014
  - Value modifier adjustments began in 2016
- Next group included solo practitioners and ACO physicians using Medicare Shared Savings quality and cost data
  - Performance measurement year – 2015
  - Value modifier adjustments began in 2017
- Eligible Professionals had to participate in PQRS in order to avoid penalties
  - Penalty for PQRS violation
  - Penalty for Value Modifier violation

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PROVIDER VALUE BASED MODIFIER

- Eligible Professionals are scored based on
  - Low quality, Average quality, High quality
  - Low cost, Average cost, High cost
- Based on where the Eligible Professional falls they will see
  - Payment increase
  - No payment change
  - Payment penalty
- To assist Eligible Professionals, CMS began issuing the Quality and Resource Use Report in 2014

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PROVIDER VALUE BASED MODIFIER

- Quality and Resource Use Report
  - The QRUR identifies all the patients that are attributed to a provider
  - totals all of the Medicare Parts A and B claims submitted by all providers who treated the patient.
  - The Cost Composite Score evaluates cost based on:
    - Per Capita Costs for All Attributed Beneficiaries
    - Per Capita Costs for Beneficiaries with Specific Conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure).
  - It is important to note that if a provider do not have patients attributed to their practice or CMS is unable to calculate any of the cost measures because the provider have less than 20 cases, that provider's cost score would be classified as "average."

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PROVIDER VALUE BASED MODIFIER

- Quality and Resource Use Report
  - The Quality Composite Score is based in part on the PQRS quality measures reported. Additionally, CMS will also calculate performance on three outcome measures. The outcomes measures include
    - Two composite measures of hospital admissions for ambulatory care-sensitive conditions (one for acute conditions and one for chronic conditions) and
    - One measure of all-cause hospital readmissions.
  - PQRS performance in addition to performance on the outcomes measures will determine the provider's quality score.

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PROVIDER VALUE BASED MODIFIER

- Just as everyone is getting used to the value modifier…
- In 2019, CMS is combining all quality/cost initiatives into one program
  - PQRS
  - Meaningful use
  - Value Modifier

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FY 2019 VALUE-BASED PURCHASING PROGRAM RESULTS

- More hospitals will have an increase in Medicare payments than will have a decrease.
- More than 1,550 hospitals (55%) will receive higher Medicare payments.
- 60% of hospitals will see a change between -0.5 and 0.5% in IPPS payments, with an average net payment adjustment of 0.17%.
- The average net increase in payment adjustments is 0.61%, and the average net decrease in payment adjustments is -0.39%.
- The highest performing hospital will receive a net increase of 3.67%, and the lowest performing hospital will incur a net decrease of 1.59%.

Source: https://www.cms.gov/newsroom/fact-sheets/cms-hospital-value-based-purchasing-program-results-fiscal-year-2019

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NEW BUNDLED PAY MODELS

- CMS plans proposed to unveil a mandatory Medicare radiation oncology payment model
- Plus two new voluntary cardiac care models
- "Real experimentation with episodic bundles requires a willingness to try mandatory models." "We need results, American patients need change, and when we need mandatory models to deliver it, mandatory models are going to see a comeback."
  - HHS Secretary Alex Azar, November 15, before the Patient-Centered Primary Care Collaborative Conference

Source: https://www.modernhealthcare.com/article/20181108/NEWS/181109925

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NEW BUNDLED PAY MODELS

- A noted departure from former Secretary Price policy, which eliminated or reduced mandatory models
  - See, e.g., Comprehensive Care for Joint Replacement Model reduction of mandatory participating MSAs
- CMS reported that the mandatory CJR model reduced spending by 3.9% or $1,127 on average compared with non-participating hospitals.

Source: https://www.modernhealthcare.com/article/20181108/NEWS/181109925

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SITE-NEUTRAL PAYMENT

- MedPAC has been advocating for some time that Medicare should not pay more for care in one provider/supplier setting than another if the care can safely and effectively be furnished in a lower cost provider/supplier setting
- December 2013, MedPAC *Assessing payment adequacy and updating payments: hospital inpatient and outpatient services*
  - "One way to improve efficiency of the system is to equalize payment rates across sites of care for similar patients. Patient decisions regarding what site to use and physician decisions regarding what site to practice at can be made without the distortions of unequal payment rates."
  - Recommendation - "Pay hospitals rates that are comparable to physician office rates for services that can safely be provided in physician offices."

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SITE-NEUTRAL PAYMENT

- June 2013, MedPAC *Report to the Congress: Medicare and the Health Care Delivery System*
  - "We also estimated the combined effect on hospital-level Medicare revenue of equalizing payment rates between OPDs and ASCs for 12 APCs and equalizing payment rates for E&M visits between OPDs and freestanding offices. These combined policies would reduce program spending and beneficiary cost sharing by about $1.5 billion per year. They would save beneficiaries between $230 million and $410 million per year."

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BIPARTISAN BUDGET ACT 2015, SECTION 603

- Section 603 amends the Medicare statutory provisions for hospital OPPS payments
- General rule – Items and services furnished on or after January 1, 2017 in new "off campus outpatient departments of a provider" generally will not be paid under the Medicare OPPS but rather under other payment systems if the requirements for such payment are otherwise met
  - "Off-campus outpatient department of a provider" means the department of a provider that is not located on a hospital's "campus" (as defined in the provider-based regulations) or within 250 yards from a "remote location of a hospital" (also as defined in the provider-based regulations)

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2019 OPPS FINAL RULE SITE NEUTRAL PAYMENT

- CMS had proposed, but did not finalize a rule that an excepted off-campus provider-based department will be paid under OPPS for a service only if that service was within 19 "clinical family of services" furnished before November 2, 2015
- CMS did finalize its proposal to expand its site-neutral payment policy to clinic visit services performed in excepted off-campus PBDs
  - CY 2019 – a clinical visit service (HCPCS G0463) furnished in an excepted off-campus PBD will only be paid 70 percent of the OPPS rate
  - CY 2020 – payment will be further decreased, and excepted off-campus PBDs will be paid the site-specific Medicare Physician Fee Schedule rate for a clinic visit service (40% of OPPS)
- "To the extent that similar services can be safely provided in more than one setting, we do not believe it is prudent for the Medicare program to pay more for these services in one setting than another."

AMERICAN HOSPITAL ASSOCIATION V. AZAR

- AHA argued that site-neutral payment policies adopted in the CY 2019 OPPS final rule exceed the section 603 statutory authority, as the statute specifically excepted off-campus PBDs in operation prior to November 2, 2015
- "The statute makes clear that services provided at excepted and non-excepted off-campus PBDs should be paid pursuant to different payment systems. . . . And yet the Final Rule effectively abolishes any distinction between excepted and non-excepted entities by subjecting them both to the same payment system and rate."
- "The Final Rule is ultra vires because the Clinic Visit Policy is not budget neutral, in plain violation of the statute. By CMS's own admission, the Clinic Visit Policy set forth in the Final Rule would reduce total hospital payments by $380 million in CY 2019, and $760 million in CY 2020, with no offsetting increases in payments for other services."

AMERICAN HOSPITAL ASSOCIATION V. AZAR

- On September 17, the US District Court for the District of Columbia ruled that the 2019 OPPS final rule reducing Medicare payment rates for evaluation and management (E/M) services furnished to Medicare beneficiaries in hospital excepted off-campus hospital provider-based departments exceeded CMS's statutory authority
- The court vacated the rule.
- The rule would have reduced over a two-year period Medicare payment rates for E/M services rendered to Medicare patients in excepted off-campus provider-based departments, thereby beginning in CY 2020 equalizing the payment rate for E/M services furnished to Medicare patients in excepted off-campus provider-based departments, non-excepted off-campus provider-based departments, and physician offices.

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AMERICAN HOSPITAL ASSOCIATION V. AZAR

- The court granted plaintiffs' motion for summary judgment vacating the final rule as ultra vires but denied the plaintiffs' request for a court order requiring CMS to issue payments improperly withheld under the rule.
- The court remanded the matter for further proceedings consistent with the ruling.

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340B – AMERICAN HOSPITAL ASSOCIATION V. AZAR

- In December 2018, the US District Court for the District of Columbia found CMS exceeded its authority by reducing outpatient 340B payments by 30% for CY 2018
  - Average Sales Price minus 22.5%
- CMS had implemented the reductions in a budget neutral manner, so the Court requested briefing within 30 days of the ruling on how to implement the decision
- Court issued a permanent injunction, finding that HHS "fundamentally altered the statutory scheme established by Congress"
- Decision does not apply to expansion of 340B reductions to off-campus outpatient locations (AHA has filed a lawsuit challenging the 2019 final rule)

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340B – AMERICAN HOSPITAL ASSOCIATION V. AZAR

- On May 6, 2019, the court held that the 2018 and 2019 rate reductions were unlawful and remanded the rules back to HHS.
- The matter has been appealed by HHS.
- In the 2020 OPPS proposed rule, CMS requested comments on potential corrective actions in the event the government is unsuccessful on appeal, such as implementing a reimbursement rate of ASP plus 3 percent.

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MEDICARE SHARED SAVINGS PROGRAM FINAL RULE

- December 21, 2018, HHS, CMS released final Medicare Shared Savings Program rule
- Currently more than 10.5 million Medicare beneficiaries served by MSSP ACOs
- Most have elected to remain in Track 1 (upside only)
- Some Track 1 ACOs are increasing Medicare spending while having access to the waivers
- Low revenue ACOs (which are typically composed of physician practices and rural hospitals) outperform high revenue ACOs (typically ACOs that include hospitals)
- Final rule is designed to create "Pathways to Success" by redesigning participation options to:
  - Encourage ACOs to transition to performance-based risk more quickly
  - Increase savings for the trust funds

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ACO PATHWAYS TO SUCCESS FINAL RULE

- Rule becomes effective February 14, 2019
- Currently participating ACOs with participation agreement ending 12/31/18 had option to extend 6 months
- There will be a one-time new start date of July 1, 2019 for new and continuing ACOs; annual application cycle will resume 1/1/2020
- New and existing ACOs were required to submit non-binding Notice of Intent to Apply between January 2, 2019-January 18, 2019
- Participation agreements must be at least 5 years (compared to 3 years)

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MSSP FINAL RULE

- ACOs currently participating in a three-year agreement period under Track 1, Track 2, Track 3, and the Track 1+ Model may complete the remainder of these agreement periods.
- CMS will determine whether an ACO is:
  - Low revenue or high revenue
  - Experienced with performance-based risk Medicare ACO initiatives
- BASIC track's glide path includes 5 levels: a one-sided model available only for the first two years to most eligible ACOs and three levels of progressively higher risk in years 3 through 5 of the agreement period
  - ACOs identified as having previously participated in the program under Track 1 would be restricted to a single year under a one-sided model
  - New, low revenue ACOs that are not identified as re-entering ACOs would be allowed up to three years under a one-sided model
  - High revenue ACOs experienced with performance-based risk must enter ENHANCED track

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MSSP FINAL RULE

- Repayment mechanism arrangement requirements:
  - Annual recalculation of the amount that must be guaranteed by the repayment mechanism based on ACO participant list changes
  - Increases the threshold from the proposed rule that must be satisfied before CMS will require the ACO to increase its repayment mechanism amount
- Regional benchmarking:
  - Will use regional FFS expenditures starting in first agreement period
  - Trend and update factors will use a blend of regional and national growth rates
- Reduce opportunities for gaming:
  - Using past participation to determine available participation options
  - Monitoring for financial performance and permitting termination of ACOs with multiple years of poor financial performance
  - Modifying application review criteria to permit CMS to consider the ACO's financial performance and failure to meet quality performance standards in multiple years of the previous agreement period
  - Holding terminated ACOs in two-sided models accountable for pro-rated shared losses

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MSSP FINAL RULE

- Regulatory flexibility provisions:
  - Annual Choice of Assignment Methodology: BASIC and ENHANCED track ACOs will have the flexibility to elect prospective assignment or preliminary prospective assignment with retrospective reconciliation prior to the start of each agreement period, and to change that selection for each subsequent performance year of the agreement period.
  - Expand Use of Telehealth for Practitioners in ACOs in Performance-Based Risk Arrangements: Beginning in January 1, 2020, eligible physicians and practitioners in applicable ACOs in performance-based risk tracks will receive payment for telehealth services furnished to prospectively assigned beneficiaries even if the otherwise applicable geographic limitations are not met, including when the beneficiary's home is the originating site.
  - Expanded SNF 3-day rule waiver eligibility for ACOs in performance-based risk within the BASIC track's glide path or under the ENHANCED track. Amended the existing SNF 3-day rule waiver to allow critical access hospitals and other small, rural hospitals operating under a swing bed agreement to be eligible to partner with eligible ACOs as SNF affiliates for purposes of the SNF 3-day rule waiver.

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MSSP FINAL RULE

- Beneficiary engagement:
  - Beneficiary Incentive Programs: ACOs under certain two-sided models will have the opportunity to apply to operate a beneficiary incentive program of up to $20 to an assigned beneficiary for each qualifying primary care service that the beneficiary receives from certain ACO professionals, or from an FQHC or RHC
  - Beneficiary Notification: An ACO must ensure that Medicare FFS beneficiaries are notified about:
    - its ACO providers/suppliers are participating in the MSSP;
    - the beneficiary's opportunity to decline claims data sharing;
    - the beneficiary's ability to, and the process by which, he or she may identify or change identification of the individual he or she designated as their primary clinician for purposes of voluntary alignment
    - the availability of the beneficiary incentive program, if offered by ACO
  - Allow ACOs to elect an "opt-in" methodology whereby a beneficiary would be assigned to an ACO if the beneficiary "opted-in" to the ACO.

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PATHWAYS TO SUCCESS SUMMARY

	BASIC Track's Glide Path Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward)	ENHANCED Track (Track 3) (risk/reward)
Shared Savings (once MSR met or exceeded)	1st dollar savings at a rate up to 40% based on quality performance; not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	No change. 1st dollar savings at a rate of up to 75% based on quality performance, not to exceed 20% of updated benchmark
Shared Losses (once MLR met or exceeded)	N/A	1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program capped at 1 percentage point higher than the benchmark nominal risk amount (e.g., 8% of ACO participant revenue in 2019 – 2020, capped at 4% of updated benchmark)	No change. 1st dollar losses at a rate of 1 minus final sharing rate, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark
Annual choice of beneficiary assignment methodology?	Yes	Yes	Yes	Yes	Yes
Annual election to enter higher risk?	Yes, but new low revenue ACOs may elect an additional year under Level B if they commit to completing the remainder of their agreement under Level E.	Yes	No; ACO will automatically transition to Level E at the start of the next performance year, except for July 1, 2019 starters that elect to enter at Level D	No; maximum level of risk / reward under the BASIC track	No; highest level of risk/reward under Shared Savings Program

APPENDIX A: COMPARISON OF BASIC TRACK AND ENHANCED TRACK CHARACTERISTICS

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PATHWAYS TO SUCCESS CONT'D

	BASIC Track's Glide Path Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward	ENHANCED Track (Track 3) (risk/reward)
Advanced APM status under the Quality Payment Program?	No	No	No	Yes	Yes
Beneficiary Incentive Program	No	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years
Expanded Telehealth Services	N/A	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years
3-Day SNF Rule Waiver	N/A	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years

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COMPLIANCE OPPORTUNITIES

- Team player – make sure Compliance is at the table for reimbursement discussions
- Learn the laws, rules and regulations so you can assist your providers in meeting requirements
- Educate on the laws, rules, regulations
- Review applicable reports and assist providers in understanding the information (and the need to view the reports)
- Audit/Monitor physician documentation, costs of care
  - Provide oversight to ensure responsible parties understand what needs to be done
  - Look for more efficient and effective ways to document required information

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COMPLIANCE OPPORTUNITIES

- Communicate
- Educate
- Be a good resource to all your practitioners and office staffs

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QUESTIONS?

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THANK YOU!

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