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

D. Scott Jones, CHC  
Richard E. Moses, DO, JD, FCLM

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Speakers’ Disclosure

• D. Scott Jones, CHC and Richard E. Moses, DO, JD do not have any financial conflicts to disclose.
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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
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MACRA repealed the unsustainable “Sustainable Growth Rate” or SGR formula, which could have resulted in a 21% Physician Fee Schedule reduction in 2015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

Cost: U.S. Healthcare Cost Per Capita Doubles That of Other Developed Nations


Medical Over-Utilization

• Healthcare compliance investigations recover $3B per 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 million

CMS Authorized Programs & Activities

• Reducing & Preventing Hospital-Acquired Infections
• Reducing & Preventing Adverse Drug Events
• Community Living Council
• Multiple Chronic Conditions
• National Alzheimer’s Project Act
• Partnership for Patients
• Million Hearts
• National Quality Strategy
• Dimay.gov

• Accountability Care Organizations
• Community-Based Transitions Care Program
• Dual-eligible coordination
• Care model demonstrations & projects
• 1115 Waivers

• Fraud & Abuse Enforcement
• National & Local decisions
• Mechanisms to support innovation (OEI, value-based review, etc.)
• Hospital Accountability Quality Hospital Discharge Inpatient psychiatric hospitals
• Home Health Nursing Homes
• Home Health Agencies
• Long Term Care Acute Hospitals
• Inpatient rehabilitation facilities
• Hospitals
CMS QUALITY PAYMENT PROGRAM (QPP)

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- MACRA Repealed the Sustainable Growth Rate (SGR) formula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)

QPP Participation

• Not participating in the QPP in 2017 results 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 APM program, such as an ACO, or report independently through the 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

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
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?

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
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

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.
MIPS Scoring

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

APMs 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
### Advanced APMs

- A subset of APMs 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
- APMs and Advanced APMs may earn a +5% annual bonus

### 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
What is the Projected Performance Threshold 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

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
  - Cannot increase the overall CMS budget
Audit Points

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

Quality Payment Program Home Page

https://qpp.cms.gov
QPP
IMPLEMENTATION

• 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 reporting can result in a modest positive payment adjustment
• No participation: negative - 4% payment adjustment
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

Reporting Due Date

• Data submission date for 2017 is March 31, 2018
• Data submission dates for subsequent years will also fall on March 31 of the year after the performance measure year
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

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?
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 APMs: report through APM
- Quality measures list and selection tool are available at https://qpp.cms.gov/measures/quality

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 APMs: full credit is given based on APM requirements
- Improvement activities list and selection tool are available at: https://qpp.cms.gov/measures/ia
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

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 (CPGs)
  • Improve cost containment measures in the practice
• https://qpp.cms.gov/measures/performance
QPP: MIPS and APM
Educational Resources

• Visit the Educational Resources section of the QPP homepages 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 APMs operated by CMS and learn more about Advanced APMs:
  • https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf

BIG DATA
DOCTORS-ON-LINE
Audit Points: Physician Compare

- JAMA: 65% of consumers are aware of on-line 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

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
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%)

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.
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 APMs receive 40 points credit (Shared Savings, Oncology Track)
  - Other APMs receive 50% credit, and may report additional activities to gain a full score

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
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

MALPRACTICE & QUALITY
**Clinical Practice Guidelines (CPGs)**

- Agency for Healthcare Research and Quality (AHRQ) maintains the National Guidelines Clearinghouse
- Evidence-based CPGs 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

**CPGs 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
Quality Payment Program & Medical Negligence Concerns: CPGs

• The role of CPGs
  • Not yet considered a Standard of Care
  • May be used as evidence by medical experts in testimony
  • Rapidly increasing number of CPGs
  • 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

Quality Payment Program & 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
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

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?
Quality Payment Program & 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

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
SUMMARY
&
CONCLUSIONS

D. Scott Jones, CHC

• Chief Compliance Officer – Augusta Health
• Compliance, Risk and Claims for 3600 providers
• Former medical practice & hospital administrator
• Author, on quality, practice management, compliance
• Frequent speaker to state, regional and national organizations
• Over 1000 compliance risk assessments for healthcare organizations nationwide
• Sjones1@augustahealth.com
• (540) 245-7455 (office)
• (610) 564-1757 (cell)
Richard E. Moses, D.O., J.D.

- Practicing Gastroenterologist for over 30 years
- Board Certified:
  - Gastroenterology
  - Internal Medicine
  - Forensic Medicine
- Chair, Department of Medicine, Jeanes Hospital, Temple University Health System
- Adjunct Clinical Professor of Medicine, Temple University School of Medicine
- Adjunct Professor of Law, Temple University Beasley School of Law
- National Speaker, Author, Educator, and Consultant on Medical, Risk and Compliance education
- remoses@mosesmedlaw.com
- www.medlawcompliance.com
  - (215) 742-9900

Thank You

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