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

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

Speaker's CME Disclosure

• Michelle Moses Chaitt, J.D. and D. Scott Jones, CHC, have no financial conflicts to disclose.
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Quality and Value Healthcare – 2017 and Beyond

The Future of MACRA Payment Reform

- 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- MACRA repealed the unsustainable “Sustainable Growth Rate” or SGR formula, which could have resulted in a 21% Physician Fee Schedule reduction in 2015.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/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

The 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- MACRA Repealed the Sustainable Growth Rate (SGR) Formula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 CY 2017 will result 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 Advanced Alternative Payment Model (APM) program, such as an ACO, or report independently through the Merit Based Incentive Program (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 will impact 2019 reimbursement.
- Four measurement categories include:
  - Quality (60% for 2017)
  - Advancing Care Information (ACI, renamed from Meaningful Use) (25% for 2017)
  - Clinical Improvement Activities (CPIA) (15% for 2017)
  - Cost (0% for 2017, but will be weighted for 2018 and beyond)

APM's 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 APM’s

- A subset of APM’s, 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
- APM’s and Advanced APM’s 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 PT 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 (does not 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

- CMS provides a comprehensive Home Page for QPP information.
- https://qpp.cms.gov/
Transitional Year 2017: Pick Your Pace

- 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:
• 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 APM’s: 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 APM’s: 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 (CPG's)
  – 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 home pages 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 APM's operated by CMS, and learn more about Advanced APM's:
• 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 online 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 APM’s receive 40 points credit (Shared Savings, Oncology Track)
  - Other APM’s 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.
A 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 + 12.5 + 11.25 + 0 = 65.8

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Malpractice and Quality

CPG’s 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](https://nccih.nih.gov/health/providers/clinicalpractice.htm)
Clinical Practice Guidelines (CPG’s)
• Agency for Healthcare Research and Quality (AHRQ) maintains the National Guidelines Clearinghouse.
• Evidence-based CPG’s 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/

Quality Payment Program and Medical Negligence Concerns: CPG’s
• The role of CPG’s:
  – Not yet considered a Standard of Care
  – May be used as evidence by medical experts in testimony
  – Rapidly increasing number of CPG’s
  – 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 and 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?


Compliance and Quality of Care Investigation
Quality of Care Investigation

• St. Josephs’ Medical Center, Baltimore, MD opens new, state of the art Cardiac Catheterization Laboratory in 2008.
• 1/2008: Retains leading NE area interventional cardiologist, Mark Midei, MD as Director.
• Cath Lab quickly becomes the “go to” facility for difficult cases and stent placement.
• Stent utilization exceeds all manufacturer’s prior records, according to e-mail messages by manufacturer later discovered during investigation → over 1000 stents are placed in 2008.

Quality of Care Investigation

• 11/08 & 4/09: In two letters, staff complain to the State Board of Physicians of 36 & 41 patients with “unnecessary stents.”
• 4/09: Hospital employee who had a stent placed files a qui tam complaint with the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) complaining he/she received a stent that was not medically necessary. DHHS joins suit.
• 6/09: OIG begins a civil investigation.

Quality of Care Investigation

• 4/09 to 6/09: 658 stent placements are reviewed as “not medically necessary.”
• 4/09 to 6/09: Hospital relieves Dr. Midei, and eventually the CEO, CFO & other administrative staff.
• 10/09 to 2/10: Letters are sent advising patients to consult with their Cardiologist, because of unnecessary stents.
• Extensive advertising by the plaintiff’s bar ensues, including Super Bowl ads.
Quality of Care Investigation

• 2/10: Dr. Midei is the subject of a highly publicized U.S. Senate Finance Committee investigation.
• 11/10: Hospital settles the OIG’s charges for $22M and enters a Corporate Integrity Agreement (CIA).
• 7/11: Dr. Midei’s license to practice medicine is revoked by the State Board of Medicine on the basis of four medical records.
• Hundreds of medical malpractice lawsuits filed against Dr. Midei and the hospital.

Quality of Care Investigation

• A media frenzy is ignited, with repetitive, negative news stories about Dr. Midei, the hospital, and parent company, Catholic Health Initiatives (CHI).
• 3/12: St. Josephs’ Hospital announces sale to the University of Maryland Medical System. Patient utilization is at record lows. The Cath Lab is virtually closed.
• 2013: The first 21 “unnecessary stent” suits to reach court were consolidated into a single trial…. Rather than face future consolidated trials, defendants settled a group of over 200 cases for approximately $36M.

Quality of Care Investigation

• 2014: Weinberg v. St. Joseph’s Medical Center. Dr. Mark Midei. Plaintiff claims Mr. Weinberg quit his casino development job and lost $50M after stent placement.
• Phase I Trial: Jury deadlocked on negligence, eventually finds Dr. Midei guilty of medical negligence.
• Phase II Trial: Jury deadlocked on damages. Mistrial. Finding of negligence vacated with prejudice.
• Plaintiff’s agreed prior to mistrial to accept a high/low arbitration of $500K to $15M. Mistrial payment: $500K.
Quality of Care Investigation

• Remaining stent claims all settled without trial.
• Estimated total indemnity cost: $100 Million.
• Hospital almost closed, and was sold by its' parent company.
• Physician lost license.
• 658 patients were affected.
• Over 600 medical malpractice suits were filed.
• Could a quality audit have identified unusual utilization?

Quality Payment Program and 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.

Conclusions

Q&A
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

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HEALTHCARE COMPLIANCE and RISK MANAGEMENT?

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