Physician Profiling: What Payors are doing with your data

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Texas Medical Association
Physicians Caring for Texans

Payment Advocacy Department

- Member benefit!
- TMA Hassle Factor Log Program
- All health plans including Medicare and Medicaid
  - Fully and self-funded plans
- Complaints = Policy Changes, Accountability and/or Legislative Changes
- Physicians or their designated staff

#1 thing to do if you provide Medicare services

- Verify your MIPS participation status
  - https://qpp.cms.gov/
- Decide what to do if you show up as needing to submit data. Impacts 2019 payments. Start between 01/01/17 and **10/02/17**
  - Submit nothing get -4% adjustment
  - Submit minimum get 0% adjustment
  - Submit 90 days of data get neutral or positive adjustment
  - Submit full year may earn positive adjustment

Physician Designation Programs

- Aetna Aexcel Designation

Orthopedics	**Osteoporosis management following fracture** Members age 50 years and older with a fracture of the hip, spine or distal radius who had a central DXA measurement ordered or performed, or pharmacologic therapy prescribed	American Medical Association PCPI Learn more: www.ama-assn.org/ama/pub/category/2946.html NCQA Learn more: http://web.ncqa.org/
Neurology	**Annual monitoring of anticonvulsant therapy** Members on anticonvulsants who had at least one drug serum concentration level monitoring test	CMS uses 30-day readmits as a marker for case review. Learn more: http://www.cms.hhs.gov
All specialty categories Cardiology, Cardio-Thoracic surgery, Gastroenterology, Obstetrics & Gynecology, Orthopedics, General surgery, Urology, Otolaryngology (ENT), Neurosurgery, Neurology, Plastic surgery, Vascular surgery	**Expected rate of readmission to the hospital once a member is discharged** Measurement used to determine when a member is unexpectedly readmitted to the hospital within 30 days after being discharged from the hospital **Number of complications or problems for hospitalized members** Measurement used to determine when a complication or problem occurs	The adverse event rate/index (number of complications or problems for hospitalized members) is consistent with AHRQ quality indicators. AHRQ is part of the National Institutes for Health. Learn more: www.ahrq.gov CMS uses 30-day readmits as a marker for case review. Learn more: www.cms.hhs.gov

- UHC Premium Designation
  - See attachments on details on cost and quality

Neurosurgery, Orthopaedics and Spine	Achilles Tendon Repair; Ankle Ligament Repair; Arthroscopic Removal of Foreign Body/Debridement - Shoulder; Arthroscopic Repair - Rotator Cuff; Arthroscopic Repair - Slap Shoulder; Arthroscopy of the Hip; Bunionectomy; Carpal Tunnel Release - Arthroscopic; Carpal Tunnel Release - Open; Cervical Spine Fusion; Cervical Spine Fusion with Hardware Insertion; Decompression - Herniated Disc/ Lumbar Back; Decompression - Herniated Disc/Lumbar Back with Revision; Fusion - Lumbar Back; Fusion - Lumbar Back with Hardware Insertion; Hip Replacement; Hip Replacement Revision; Knee Arthroscopy with Cruciate Ligament Repair; Knee Arthroscopy with Meniscectomy; Knee Replacement Surgery; Other Knee Arthroscopy with Treatment; Rotator Cuff Repair; Shoulder Arthroscopy with Claviculectomy, Tenodesis, or Capsulorrhaphy; Shoulder Arthroscopy with Synovectomy or Lysis Adhesions

- Cigna Care Designation
  - The assessment review period for Cigna Care designation and quality and cost-efficiency displays for 2017-2018 is January 1, 2014 through December 31, 2015. This review includes claims data from Cigna Managed Care and PPO plans. The current 2017 Cigna Care designation and physician quality and cost - efficiency displays in the directory will remain in effect through December 31, 2018.
  - Orthopedics only looks at cost-efficiency

- Humana – no current program
- BCBS Texas – current program does not include orthopedics

Problems with “Designation” programs

- 2 messages delivered with these types of programs
  - Patients and employers should use the designation program to make decisions about who should be trusted to provide medical care; and
  - When making medical decisions, physicians should pay attention to what insurers deem important in the care of patients.
- Insurers often did not take steps to make the programs meaningful and reliable.

- Insurers did not:
  - Provide patients and physicians with adequate descriptions of the ratings program;
  - Describe the limited role such ratings should play in patient decision making;
  - Inform physicians of the fundamental aspects of the ratings system;
  - Provide processes to protect professional reputations from incorrect designations;
  - Undertake internal or external reviews to review the veracity of the data upon which designations are based; and
  - Execute a commitment to improve quality based on the review.

Legislator and Administrative Response

- Physician consternation with designation programs (introduced around 2003-2005) and the demonstrable insurer blunders in individual cases spurred regulatory responses in several states.
  - NY Attorney General, after an inquiry, executed an agreement with United Healthcare on its Premium Designation Program and investigated the Aetna Aexcel program (2007).
  - Colorado passed the Physician Designation Disclosure Act (2008).
  - Texas passed HB1888 (2009) establish "standards required for certain rankings of physicians by health benefit plans."

HB 1888 Basic Protections (Chapter 1460, Insurance Code)

- You are provided notice (45 days) prior to publication
- You must be provided access to the information you need to dispute a ranking (methodology and all data used)
- You may request a face-to-face or telephone hearing
  - Make the request in 30 days; Entitled to have someone represent you; Entitled to provide information to the decision maker; Entitled to a written decision
- Physicians in active practice (USA) must participate in standards creation
- Measures must be transparent and valid

Steps to review and dispute ranking/tiering

- Step 1 - Collect and review ALL letters and documentation received from the health plan
  - Letter saying you're subject to ranking/tiering
  - Data available via health plan portal
  - Data on the health plan website
- Step 2 - Determine if plan is subject to Texas law
  - Doesn't apply to rankings by Medicaid, Medicaid MC, CHIP, MA plan, Medicare supplemental plan

- Step 3 - Determine basis for appeal, if possible, or request more information. Some examples of why you might appeal
  - The ranking is based upon inaccurate data (e.g., wrong patient data)
  - The ranking is based solely on cost measures (rather than cost measures used in conjunction with quality measures as is required under Chapter 1460 of the Texas Insurance Code)
  - The standards and measurements used were not disclosed to you before the evaluation period for the ranking (as is required under Chapter 1460). Instead, the standards and measures were applied retroactively and based upon old data.
  - The standards and measures used in the program fail to comply with the hierarchy of standards established under the law and the regulations.
  - The program did not have physicians currently in clinical practice actively involved in the development of the standards used in the comparison program (as is required by Texas Insurance Code §1460.006)
  - The measures and methodology used in the comparison program are not transparent and /or valid and are, therefore, in contravention of Texas Insurance Code §1460.006.

- Note that 28 Tex. Admin. Code §21.3202(d)-(f) provides that a health benefit plan issuer (HBPI) that uses a physician ranking system is required to **first follow the endorsed measures, guidelines and standards of the NQF or the AQA Alliance.** If neither NQF nor AQA Alliance has an endorsed measure, guideline, or standard regarding an issue, **then the HBPI must follow the endorsed measures, guidelines, and standards of the NCQA and other similar national organizations**. If the NQF, AQA Alliance, or other national organizations (including NCQA) have not established standards or guidelines regarding an issue, **then the HBPI must follow measures, guidelines and standards based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship standards adopted by the Commissioner** (after petitioning for rule-making with the Department to request that the Commissioner consider adopting other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship standards for use in the HBPI's physician ranking system). See 35 TexReg 3841.

- Step 4 – Initiate the appeal/dispute process. Under Texas law, each physician is afforded, before the publication or other public dissemination, of a ranking, an opportunity to dispute the ranking through a process that includes certain due process protections (as noted below).
  - **Request data/information pertinent to the ranking/tiering.** If you have not been provided with enough information to analyze and/or adequately challenge your ranking, request the additional data that is needed.
    - Under Texas law, the health plan is required to provide at least 45 days' written notice to the physician of the proposed ranking, "including the methodologies, data, and all other information utilized by the plan …" in its ranking/tiering.

- **Request a review/fair reconsideration proceeding within 30 days of receiving notice of the ranking** (along with the information utilized by the plan in its ranking decision).
  - If timely requested, the plan must provide (in addition to any written fair reconsideration process) a fair reconsideration proceeding, which may be conducted (at the physician's option): 1) by teleconference, at an agreed upon time; or 2) in person, at an agreed upon time, or between 8 am and 5 pm, Monday through Friday.
- **Prepare for the fair reconsideration proceeding.** Under Texas law, the physician has a right to provide information at the requested proceeding, have a representative participate in the proceeding, and submit a written statement at the conclusion of the proceeding. To most effectively challenge a ranking, the physician should prepare all the necessary information/statements in advance.
  - Texas law requires the plan to provide a written communication of the outcome of the proceeding (including the specific reasons for its decision) prior to any publication or dissemination of the ranking.

- Step 5 – If you believe the health plan has not adhered to the requirements of Chapter 1460, Insurance Code, file a complaint with TDI
  - Email: ConsumerProtection@tdi.state.tx.us
  - Mail: Texas Department of Insurance Consumer Protection; PO Box 149091; Austin, Texas 78714-9091
  - Fax: (512) 490-1007

Use of data

- Narrow networks
  - Commercial and MA plans
- Plan design with less cost share for “designated” physician
- Transparency
- Future bundled payment models
- Termination from network

Medicare Quality Program

- 2018 PQRS downward payment adjustment coming
  - Based off 2016 PQRS reporting (now it's MIPS)
  - **REVIEW YOUR REPORTS!**
    - Available for every Taxpayer Identification Number (TIN) under which at least one individual EP (identified by his or her National Provider Identifier, or NPI) or PQRS group practice submitting Medicare Part B Physician Fee Schedule (PFS) claims reported at least one valid PQRS measure a minimum of once during the reporting period.
  - **File an informal review 9/18-12/01**
  - Step by step instructions attached

Possible measures reported (examples)

- Medication reconciliation
- BMI screening
- Osteoarthritis assessment for function/pain
- Falls risk assessment and plan of care
- Opioid therapy
- Specific for hip, knee, spine, wrist

Medicare Physician Compare

- CMS MLN Provider Call on Physician Compare
  - 09/28/2017 12:30 – 2:00 PM
  - Discuss upcoming 30 day preview period for 2016 performance data targeted for release in December
  - https://blh.ier.intercall.com/details/d504665d6dc94831b581cef68c59166c

- Update data on Physician Compare
  - Some data is pulled from PECOS so make sure your PECOS record is correct
  - Specific data and how to update it can be found on the CMS website
    - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/How-to-Update-your-Data-on-Physician-Compare.html

2014

- 2013 PQRS, GPRO, eRx & EHR Incentive Program Participation
- 2013 PQRS Maintenance of Certification Incentive
- 2012 PQRS GPRO & ACO measures (February 2014)
- 2013 PQRS GPRO & ACO measures (December 2014)
- 2013 CAHPS for ACO measure (December 2014)

2015

- 2014 PQRS, GPRO, & EHR Incentive Program Participation
- 2014 Maintenance of Certification Incentive
- 2014 PQRS GPRO measures
- 2014 ACO measures, including CAHPS for ACOs
- 2014 CAHPS for PQRS measures
- 2014 Individual EP PQRS measures
  - Sub-set of 20
- Measures from the 2014 Cardiovascular Prevention measures group in support of Million Hearts

2016 and beyond

- 2015 PQRS, GPRO, & EHR Incentive Program Participation
- 2015 PQRS GPRO measures
- 2015 ACO measures, including CAHPS for ACOs
- 2015 CAHPS for PQRS measures
- 2015 Individual EP PQRS measures
- 2015 QCDR measures
  - Individual EP-level
  - PQRS and non-PQRS measures
  - No first year measures
- 2015 Individual EP PQRS Measures in support of Million Hearts

2015 Individual Clinician Measures Publicly Reported on Physician Compare in December 2016

Orthopedics				
PQRS measure number	**Technical measure title**	**Plain language measure title**	**Plain language measure description**	**Reporting mechanism**
24	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Osteoporosis care coordination for older women with hip, spine, or wrist fractures.	More stars are better because it means this clinician communicated that a fracture happened to patient's regular clinician more often. This clinician also recommended the patient get tested or treated for osteoporosis when appropriate. Typically the clinician treating a fracture is not the same person who is responsible for the patient's ongoing care. It is important that the regular clinician is aware of the bone fracture since older patients with fractures should be tested or treated for osteoporosis. To give this clinician a score, Medicare looked at the percentage of this clinician's female patients ages 50 and older with hip, spine, or wrist fractures with documented communication between this clinician and the clinician managing the patient's ongoing care. This includes documentation of the fracture and whether the patient was or should be tested or treated for osteoporosis.	Registry
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	Screening for osteoporosis in older women.	More stars are better because it means more of this clinician's female patients either had an X-ray to check for osteoporosis or got treatment for osteoporosis when appropriate." Older women have a higher risk of developing osteoporosis, a disease that causes bones to weaken. To give this clinician a score, Medicare looked at the percentage of this clinician's female patients ages 65 and older who were screened for osteoporosis or got medicine to treat osteoporosis when appropriate.	Claims
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Giving patients who fracture their hip, spine, or wrist an X-ray or medicine that treats osteoporosis.	More stars are better because it means this clinician gave X-rays or medicine that treats osteoporosis to more patients who fractured their hip, spine, or wrist when appropriate. Patients who fracture their hip, spine, or wrist are at risk of osteoporosis, a condition that causes weak bones. Clinicians can give patients with these fractures an X-ray or medicine that treats osteoporosis to help manage symptoms of osteoporosis. To give this clinician a score, Medicare looked at the percentage of this clinician's patients who fractured their hip, spine, or wrist and got an X-ray or medicine for osteoporosis when appropriate.	Registry

2015 Individual Clinician Measures Publicly Reported on Physician Compare in December 2016

Orthopedics				
PQRS measure number	**Technical measure title**	**Plain language measure title**	**Plain language measure description**	**Reporting mechanism**
109	Osteoarthritis (OA): Function and Pain Assessment	Checking functional and pain status in patients with osteoarthritis.	More stars are better because it means this clinician checked the functional status and pain of more patients with osteoarthritis. Functional status is a measure of a patient's physical limitations and ability to perform daily tasks. Patients with osteoarthritis can become very weak, so checking their pain and functioning is important and can lead to better outcomes. To give this clinician a score, Medicare looked at the percentage of this clinician's patients with osteoarthritis who had their pain and functional status checked.	Claims
182	Functional Outcome Assessment	Checking functional status and developing a follow up plan.	More stars are better because it means this clinician checked the functional status of more patients with musculoskeletal conditions and developed a follow-up plan. Functional status is a measure of a patient's physical limitations and ability to perform daily tasks. Checking functional status can help patients get recommended treatment. To give this clinician a score, Medicare looked at the percentage of this clinician's patients whose functional status was checked, and if they had functional issues, had a follow-up plan developed.	Claims
218	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments	Checking functional status after hip treatment.	More stars are better because it means this clinician checked the functional status of more patients with hip injuries before and after treatment. Functional status is a measure of a patient's physical limitations and ability to perform daily tasks. Checking functional status can help patients get recommended treatment. A change in functional status over the course of treatment can be used by clinicians to evaluate whether treatment is successful. To give this clinician a score, Medicare looked at the percentage of this clinician's patients with a hip injury whose functional status was measured before and after treatment.	Registry

2015 Individual Clinician Measures Publicly Reported on Physician Compare in December 2016

Orthopedics				
PQRS measure number	**Technical measure title**	**Plain language measure title**	**Plain language measure description**	**Reporting mechanism**
219	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments	Checking functional status in patients getting treated for lower leg, foot, or ankle injuries.	More stars are better because it means this clinician checked the functional status of more patients with lower leg, foot, or ankle injuries before and after treatment. Functional status is a measure of a patient's physical limitations and ability to perform daily tasks. Checking functional status can help patients get recommended treatment. A change in functional status over the course of treatment can be used by clinicians to evaluate whether treatment is successful. To give this clinician a score, Medicare looked at the percentage of this clinician's patients with lower leg, foot, or ankle injuries whose functional status was measured before and after treatment.	Registry
223	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments	Checking functional status of patients getting treated for neck, head, jaw, upper back, middle back, or other general orthopedic injuries.	More stars are better because it means this clinician checked the functional status of more patients with neck, head, jaw, upper back, middle back, or other general orthopedic injuries before and after treatment. Functional status is a measure of a patient's physical limitations and ability to perform daily tasks. Checking functional status can help patients get recommended treatment. A change in functional status over the course of treatment can be used by clinicians to evaluate whether treatment is successful. To give this clinician a score, Medicare looked at the percentage of this clinician's patients with neck, head, jaw, upper back, middle back, or other general orthopedic injuries whose functional status was measured before and after treatment.	Registry

2015 Group Measures publicly reported on Physician Compare in December 2016

Orthopedics				
PQRS measure number	**Technical measure title**	**Plain language measure title**	**Plain language measure description**	**Reporting mechanism**
24	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Osteoporosis care coordination for older women with hip, spine, or wrist fractures.	More stars are better because it means clinicians in this group communicated that a fracture happened to patient's regular clinician more often. This clinician also recommended the patient get tested or treated for osteoporosis when appropriate. Typically the clinician treating a fracture is not the same person who is responsible for the patient's ongoing care. It is important that the regular clinician is aware of the bone fracture since older patients with fractures should be tested or treated for osteoporosis. To give this group a score, Medicare looked at the percentage of this group's female patients ages 50 and older with hip, spine, or wrist fractures with documented communication between clinicians at this group and the clinician managing the patient's ongoing care. This includes documentation of the fracture and whether the patient was or should be tested or treated for osteoporosis.	Registry
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	Screening for osteoporosis in older women.	More stars are better because it means more of this group's female patients either had an X-ray to check for osteoporosis or got treatment for osteoporosis when appropriate. Older women have a higher risk of developing osteoporosis, a disease that causes bones to weaken. To give this group a score, Medicare looked at the percentage of this group's female patients ages 65 and older who were screened for osteoporosis or got medicine to treat osteoporosis when appropriate.	Registry
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Giving patients who fracture their hip, spine, or wrist an X-ray or medicine that treats osteoporosis.	More stars are better because it means clinicians in this group gave X-rays or medicine that treats osteoporosis to more patients who fractured their hip, spine, or wrist when appropriate. Patients who fracture their hip, spine, or wrist are at risk of osteoporosis, a condition that causes weak bones. Clinicians can give patients with these fractures an X-ray or medicine that treats osteoporosis to help manage symptoms of osteoporosis. To give this group a score, Medicare looked at the percentage of this group's patients who fractured their hip, spine, or wrist and got an X-ray or medicine for osteoporosis when appropriate.	Registry

2015 Group Measures publicly reported on Physician Compare in December 2016

Orthopedics				
PQRS measure number	**Technical measure title**	**Plain language measure title**	**Plain language measure description**	**Reporting mechanism**
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	Giving medicine to older patients who have osteoporosis.	More stars are better because it means clinicians in this group gave medicine to more older patients who have osteoporosis when appropriate. Osteoporosis is a disease that makes bones weaker and can increase the risk of breaking a bone. Medicine for osteoporosis can make fractures or breaks less likely and can help make bones stronger. To give this group a score, Medicare looked at the percentage of this group's older patients who have osteoporosis and got medicine such as bisphosphonates and estrogens, to treat their osteoporosis when appropriate.	Registry
109	Osteoarthritis (OA): Function and Pain Assessment	Checking functional and pain status in patients with osteoarthritis.	More stars are better because it means clinicians in this group checked the functional status and pain of more patients with osteoarthritis. Functional status is a measure of a patient's physical limitations and ability to perform daily tasks. Patients with osteoarthritis can become very weak, so checking their pain and functioning is important and can lead to better outcomes. To give this group a score, Medicare looked at the percentage of this group's patients with osteoarthritis who had their pain and functional status checked.	Registry
182	Functional Outcome Assessment	Checking functional status and developing a follow up plan.	More stars are better because it means clinicians in this group checked the functional status of more patients with musculoskeletal conditions and developed a follow-up plan. Functional status is a measure of a patient's physical limitations and ability to perform daily tasks. Checking functional status can help patients get recommended treatment. To give this group a score, Medicare looked at the percentage of this group's patients whose functional status was checked, and if they had functional issues, had a follow-up plan developed.	Regist

Overwhelmed!

- Subscribe to Action, E-Tips and other relevant newsletters
- Complete the TMA survey (sent via e-mail every even numbered year)
  - Doctor interested but not receiving request? E-mail me!
- PaymentAdvocacy@texmed.org
- 512/370-1414 or 1-800-880-1300 and ask for Payment Advocacy Department