Washington Update

Presented by MGMA Government Affairs

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Agenda

• Latest legislative and regulatory news
• Key 2016 Medicare updates
• PQRS, VBPM, Meaningful Use, Oh my!
• MACRA 101
• Discussion of *newly released* proposed rule
• Looking ahead in 2016: presidential year politics
Latest federal legislative and regulatory news
Recent Legislation and Regulation

Bipartisan Budget Act of 2015 (H.R. 1314)
• New provider-based, off-campus outpatient depts will be paid under physician or ASC fee schedules (instead of OPPS) starting Jan. 1, 2017
  * Existing depts will be grandfathered in (cutoff: Nov. 2, 2015)

60-day Repayment Final Rule (FR link)
• “A person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount..."
• Applies to Part A & B Medicare payments going back 6 years
  *MGMA resources: webinar and analysis
CONNECT for Health Act (S 2484/HR 4442)

- Expands coverage for telehealth services in Medicare by lifting a number of restrictive coverage requirements
- Has bipartisan support in both Houses
- Creates an avenue for telehealth and remote patient monitoring services to satisfy future payment models
- Permits use of remote patient monitoring for certain Medicare patients with chronic conditions

**Action Steps >>**

Read MGMA’s [letter of support](#)
Visit our [Contact Congress portal](#) to show your support
Flexibility in EHR Reporting Act

- S. 2822/H.R. 5001
- Has Bipartisan support in both Houses
- Provides for the use of a 3 month quarter reporting period for Meaningful Use regardless of payment year or stage of MU
**HIPAA**

**Phase 2 audits:** OCR will notify via e-mail; have 10 business days to respond and verify contact information via online portal
- May initiate subsequent “desk” or on-site audits

**Action steps >>**
1. Check spam folder for OCR emails
2. Review and update your security risk analysis for more common meaningful use audits by Figliozzi
3. Access MGMA’s [HIPAA resources](#) and [meaningful use audit FAQs](#)

**EFT Protections:** Lookout for increasingly common “value-added” service fees to EFT payments and virtual credit cards

**Action steps >>**
1. Request EFT in lieu of paper checks or virtual credit cards
2. Utilize MGMA’s [EFT/ERA Guide](#) and [sample letter](#) for requesting EFT payments
3. Consider lodging a complaint with OCR through MGMA
Open Payments Program (aka “Sunshine Act”)

Background
• Drug and device manufacturers must report certain transfers of value and physician ownership to CMS
• Payments of $10+ must be reported unless an exclusion applies

What’s New?
• Review and Dispute period: April 1 – May 15, 2016
• Two-step registration to review and dispute:
  1. CMS Enterprise Portal
  2. Open Payments Program

Resource
• Just updated! MGMA’s Open Payments: what you need to know
Key 2016 Medicare updates
ACP New service with two billable codes (99497, 99498); involves face-to-face discussion of long-term treatment options and planning

- MGMA Resource: Advance Care Planning Quick Guide

Incident to Can be billed only by supervising physician, but he/she need not be same physician who initially establishes patient care plan

Chronic Care Management Can be billed in RHC or FQHC; no finalized changes to reduce burdensome requirements for now…

- MGMA Resource: CCM Service Essentials

Transitional Care Management Date of service now reflects date of face-to-face visit (previously date of discharge)
Medicare Enrollment / Revalidation

Enrollment opt-out affidavits: Automatically renew every 2 yrs

MGMA Resource: Medicare Participation Decision FAQs

**Action Step >>** To cancel renewals, send written notifications to all relevant MACs at least 30 days prior to the start of a new opt-out period.

Enrollment revalidations: 2nd cycle; required every 5 yrs

**Action Steps >>**

1. **Check** PECOS and/or keep an eye out for revalidation notices from your MAC
2. **Submit** a revalidation application OR **complete** a Medicare 855 form within 6 months of your revalidation due date (PECOS recommended)
3. Visit the [website](#) or email [providerenrollment@cms.hhs.gov](mailto:providerenrollment@cms.hhs.gov) with Q’s
Visit:
mgma.org/Medicare-reimbursement

- 2016 Medicare Physician Fee Schedule Analysis
- 2016 Medicare Update Free On-Demand Webinar
Current federal quality reporting programs
Medicare penalty risk
Based on 2016 performance

Meaningful Use  PQRS  VBPM*

Practices of 10+ EPs

3-4%  2%  4%

Maximum: -10%

Practices of 9 or fewer EPs

3-4%  2%  2%

Maximum: -8%

*There are equivalent bonuses available under the Value-Based Payment Modifier.
PQRS
(Physician Quality Reporting System)
PQRS in 2016

- **2% automatic penalty** in 2018 for failing to report in 2016
- Consistent with 2015 reporting criteria: *most* reporting options require **9** quality measures that span at least **3** NQS domains
  - Plus a [cross-cutting measure requirement](#) for claims & registry reporting
- **281** total PQRS measures; **18** GPRO web interface measures
- Measures have changed in 2016 so make sure to view the [2016 PQRS measures list](#), which is sortable by reporting mechanism, NQS domain, and more.
- Qualified Clinical Data Registry reporting is now available under GPRO
- GPRO [registration](#) deadline: **June 30**
VBPM

(Value-Based Payment Modifier)
In 2018, all physicians, PAs, NPs, CNSs and CRNAs

Practices with 10 or more EPs
-4% to +4x adjustment

PQRS penalty

In addition to 2%

PQRS penalty

Practices with 9 or fewer EPs
-2% to +2x adjustment

2% penalty
In addition to 2%
PQRS penalty

Non-Satisfactory 2016 PQRS Reporters
Groups and solo practitioners that do not meet the reporting criteria to avoid the 2018 PQRS penalty

Automatic Payment Penalty

Potential Quality-Tiering Payment Adjustment

Practices with ONLY non-physician EPs
0% to +2x adjustment

Category 1

Satisfactory 2016 PQRS Reporters:
• Register for GPRO and meet reporting requirements
• Solo practitioners successfully report individually
• 50% of EPs in group successfully report individually

Category 2

Practices with ONLY non-physician EPs
-4% to +4x adjustment

0% to +2x adjustment

Practices with 9 or fewer EPs
-2% to +2x adjustment

Practices with 10 or more EPs
-4% to +4x adjustment

Practices with ONLY non-physician EPs
4% penalty
In addition to 2%
PQRS penalty

Practices with 9 or fewer EPs
2% penalty
In addition to 2%
PQRS penalty

Practices with 10 or more EPs
2016 VBPM Payment Adjustments
Based on 2014 cost and quality data

13,813 groups of 10 or more EPs are impacted by the VBPM in 2016

- 39.2% automatic -2% penalty
- 59.4% no payment adjustment
- 0.9% Quality-tiering bonus (+15.92% or +31.84%)
- 0.4% Quality-tiering penalty (-1% or -2%)

Source: CMS’ fact sheet on the 2016 VBPM results
QRURs (Quality and Resource Use Reports)

Access your 2014 QRUR for:

- Comparative cost and quality data
- Specific 2016 payment details for practices of 10+ EPs

This month! CMS released 2015 mid-year QRURs

- Previews 2017 payment

How to obtain your QRURs:

- Download via CMS Enterprise Portal
- Read 2014 QRUR Reference Guide
Looking Ahead: 

**VBPM in the 2016 performance year**

**Expands** the VBPM to PAs, NPs, CNSs and CRNAs

**Subjects** groups of 9 or less EPs to a 2% quality-tiering penalty

> Makes no change to penalties for groups of 10 or more EPs

**Exempts** a practice if at least 1 billing EP participates in one of five specified APMs (Oncology Care Model, Next Gen ACOs, Pioneer ACOs, Comprehensive ESRD Care Initiative, CPCI)

**Action Steps:**

1. Download your 2014 QRUR from the [CMS Enterprise Portal](https://www.cms.gov), which contains your 2016 payment adjustment information.

2. Download your 2015 mid-year QRUR to get an idea of where you may fall for 2017 payment adjustment.
Meaningful Use
Submit a 2015 hardship exception application by July 1.

**What’s special about 2015?** Due to delay of the modifications rule, CMS approved a blanket, streamlined exception process.

- Applies to every provider, even those who never applied to program or don’t have an EHR system.
- Forms require less information & no supporting documentation.
- One form may be submitted for all of the providers in the group.
- Applications will receive an expedited, automatic review.
- Submitting a hardship application will NOT nullify incentive $$. [FAQ]

**MGMA Tip:** Select option 2.2d citing EHR vendor issues

“Issues related to insufficient time to make changes…to meet CMS regulatory requirements for reporting in 2015.”
MU Stage 2: Key 2016 changes

Reporting period

- Full-year reporting in 2016, with a limited exception for new participants who may report for any 90 consecutive days.

10 core reporting objectives (incl. new public health obj.)

- Previously 17 core and 3 menu objectives
- Redundant and “topped out” objectives were eliminated

Reduced “patient action” measure thresholds

- Patient electronic access (view, download, transfer) objective
  5% of patients 1 patient (at least 50% provided access)
- Secure messaging objective
  5% patients 1 patient (up from demonstrating capability in 2015)

Possible penalty increase to 4%

- Agency has informally hinted 3%, still awaiting confirmation
The (Real) Future of Meaningful Use
Visit:
mgma.org/federalqualityreporting

- Meaningful Use Overview: 2015-2017
- 2016 PQRS-Value Modifier Survival Guide
- 2016 VBPM: Prepare Your Practice
- MGMA's QRUR Resource Webpage
Current programs aren’t working

A recent *Health Affairs* study of MGMA members found:

- On average, practices in four common specialties spend **785 hours** per physician and over **$15.4 billion** per year on reporting measures for federal quality programs.
- Nearly **3 in 4** practices reported being evaluated on measures that were not clinically relevant.

“The federal government needs to get out of the business of dictating patient care through wasteful mandates and create simplified systems to support medical practices in improving quality across the country.”

- MGMA President and CEO Halee Fischer-Wright
MACRA

(Medicare Access and CHIP Reauthorization Act)
After 17 years of uncertainty and 17 legislative “patches” to avert payment cuts, the failed SGR formula was finally repealed in 2015 by the Medicare Access and CHIP Reauthorization Act (MACRA).
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA):

THE BASICS
What MACRA does

- Permanently eliminates the SGR (and its annual physician payment cuts)
- Consolidates quality reporting programs
- Establishes a path for alternative payment models (APMs)
MACRA is only a framework; federal agencies have substantial discretion in the rulemaking process.

- CMS issued proposed rule in Spring 2016

2016 is a key transition year for MACRA.

- MIPS and APM requirements will be determined
- Major implications for 2017 requirements…will Admin. follow current program structure, delay MIPS, or roll out new program in time? TBD.

MGMA is actively working with government agencies and stakeholder partners to help shape regulations.

- We submitted comments to CMS on MACRA implementation
- We sit on numerous stakeholder coalitions and workgroups that work closely with the Agency to develop MIPS & APM specifications
Practices will have choices under MACRA

**Fee-for-Service under a “Merit-Based Incentive Payment System” (MIPS)**
- Statutory updates
- Consolidated reporting
- Reduced penalty risk

**Alternative Payment Models (APMs)**
- Higher updates
- Exempt from MIPS
- Preferred treatment for medical homes
- Specialty models encouraged
MACRA milestones

2016
- Last performance year for PQRS, meaningful use, and VBPM
- Proposed rule outlining MIPS and APM criteria released 4/25/16

2017
- First performance measurement year for MIPS
- APM criteria set, proposals accepted for review on an ongoing basis

2018
- Second performance measurement year for MIPS
- Separate PQRS, meaningful use, and VBPM programs / penalties sunset on Dec. 31

2019
- First MIPS payment adjustments applied, maximum ±4% (phases up to ± 9% in 2022)
- First APM performance period, 5% bonus payments made to qualifying participants
MIPS and APMs:

WHAT WE KNOW FROM THE STATUTE
Medicare payments under MACRA

Baseline
PFS
Updates
MIPS*
APMs

0.5% 0% 0.25% ±4% ±5% ±7% ±9%
5% lump sum bonus 0% +0.5% PFS

*Up to additional 10% bonus for exceptional performance
MIPS

• In 2019, Meaningful Use, PQRS, and VBPM will be streamlined into one program: the Merit-Based Incentive Payment System (MIPS)

• MIPS will calculate a single composite score based on performance in four categories:
  1. Quality
  2. Resource Use
  3. Use of EHR technology
  4. Clinical Practice Improvement Activities
Exemptions from MIPS

• The following providers will be exempt:
  ▪ First-year Medicare providers
  ▪ Providers with a low volume of Medicare patients
  ▪ Qualifying participants in eligible APMs
## 2019 (first year) penalty risks compared

<table>
<thead>
<tr>
<th>Prior Law</th>
<th>2019 adjustments</th>
<th>MIPS factors</th>
<th>2019 scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PQRS</strong></td>
<td>-2%</td>
<td>Quality measurement</td>
<td>50% of score</td>
</tr>
<tr>
<td><strong>MU</strong></td>
<td>-5%</td>
<td>MU</td>
<td>25% of score</td>
</tr>
<tr>
<td><strong>VBPM</strong></td>
<td>-4% or more*</td>
<td>Resource use</td>
<td>10% of score</td>
</tr>
<tr>
<td><strong>Total penalty risk</strong></td>
<td>-11% or more*</td>
<td>Clinical improvement activities</td>
<td>15% of score</td>
</tr>
<tr>
<td><strong>Bonus potential (VBPM only)</strong></td>
<td>Unknown (budget neutral)*</td>
<td>Total penalty risk</td>
<td>Max of -4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bonus potential</td>
<td>Max of 4%, plus potential 10% for high performers</td>
</tr>
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*VBPM was in effect for 3 years before MACRA passed, and penalty risk was increased in each of these years; there were no ceilings or floors on penalties and bonuses, only a budget neutrality requirement.*
APMs

• APM is a **generic term** describing a payment model in which providers take **responsibility for cost and quality performance** and **receive payments to support** the services and activities designed to achieve high value.

• According to MACRA, APMs include:
  - Medicare Shared Savings Program ACOs
  - Patient-centered medical homes
  - CMS Innovation Center Models
  - Other federal demonstrations
Incentives to participate in APMs

- APMs offer greater potential inherent risks and rewards than MIPS

- Under MACRA, qualifying APM participants in “eligible” APMs:
  - Are exempt from MIPS
  - Receive annual 5% lump sum bonus payments from 2019-2024
  - Receive a higher fee schedule update for 2026 and onward

- To earn incentives, qualifying APM participants must meet increasing thresholds
  - 2019 = 25% of payment or patients attributable to services furnished through an eligible APM
  - 2021 = 50%
  - 2023 = 75%
What makes an APM “eligible”? 

Under MACRA, “eligible” APMs must:

- Base payment on quality measures that are comparable to MIPS
- Require use of certified EHRs
- Bear more than “nominal financial risk” or be a medical home model
MACRA:

WHAT WE KNOW FROM THE PROPOSED RULE SO FAR
New Vocabulary in the **Proposed** Rule

- **Quality Payment Programs**
  - MIPS and APMs, MACRA

- **Eligible Clinicians**
  - Replaces eligible professionals
  - Defined as physicians, PAs, NPs, CNSs, CRNAs, and groups that include such clinicians

- **Advancing Care Information**
  - Replaces meaningful use of certified EHR technology

- **Advanced APM**
  - Instead of APM
MIPS in the Proposed Rule

• Four Categories:
  – **Quality** (50% of total score in year 1)
    • Replaces PQRS and quality component of VBPM
    • Clinicians choose to report 6 measures with at least one cross-cutting measure and an outcome measure.
      – If no outcome measure, then EC would report one other high priority measure
    • CMS: gives clinicians reporting options to choose from to accommodate differences in specialty and practices
  – **Resource Use** (10% of total score in year 1)
    • Based on Medicare claims, no reporting requirements
    • Sufficient number of Medicare patients
MIPS in the Proposed Rule

- **Clinical Practice Improvement Activities (CPIA)** (15% of total score in year 1)
  - Generally encourage reporting but no requirement for minimum number of CPIAs.
  - CMS: clinicians would be rewarded for CPIAs and may select activities that match their practices’ goals from a list of more than 90 options.
  - Receive credit if participate in APM and PCMH

- **Advancing Care Information** (formerly known as MU) (25% of total score in year 1)
  - CMS: Clinicians choose customizable measures that reflect how they use EHR technology in day to day practice
  - Assessment based on ACI measures and objectives.
MIPS in the Proposed Rule

- Reporting period is one year: Jan. 1, 2017 – Dec. 31, 2017
- Budget Neutral
- Possible positive (+4%), negative (-4%) or neutral (0%) adjustments
  - Highest performers bonus of up to 10%
- Can submit information individually or as a group or APM entity.
- Know in advance what ECs need to do to perform well
- Eliminates all or nothing scoring approach
- Feedback: First year on annual basis
- Process for public reporting of MIPS on Physician Compare
APMs in the Proposed Rule

• Advanced APMs
  – Three Requirements
  – Qualified models:
    • Comprehensive ESRD Care Model
    • CPC+
    • MSSP Track 2
    • MSSP Track 3
    • Next Generation ACO
    • Oncology Care Model Two-Sided Risk Arrangement
MIPS & APMs Proposed Rule

- MACRA is only a framework
- Federal agencies have substantial discretion in implementation via the rulemaking process
- On April 27, CMS released the hotly-anticipated MIPS and APMs proposed rule
- MGMA will be submitting comments, due on June 27
- Final MIPS and APMS rule expected this fall

Visit MGMA’s MACRA Resource Center for up-to-the-minute news and resources
mgma.org/MACRA
MIPS & APMs Proposed Rule


- **MGMA concerns**:
  - Limited time to prepare for MIPS
  - Disconnect between performance and payment limits practice ability to correct reporting issues in real time and improve quality based on actionable feedback
  - Unrealistic in this era of rapid change and advancement
MIPS & APMs Proposed Rule

- **Proposal:** Only “Advanced APMs” participants would qualify for incentive payments and exemption from MIPS
  - Qualifying models:
    - Comprehensive Primary Care Plus
    - Next Generation Accountable Care Organizations (ACOs)
    - MSSP ACOs – Tracks 2 and 3 only
    - Oncology Care Model with two-sided risk
    - Comprehensive ERSD Care
  - CMS will not notify any new APM applicants about their status until *after* the MIPS performance period begins.

- **MGMA concern:** proposed definition is significantly too narrow
Positioning practices for the future

• Fee for service payment methods are **blurring** and morphing into new payment models
• Increasing **focus on accountability** for total cost of care, while maintaining quality
• **Growing emphasis on care coordination**, health IT and patient satisfaction
• Practices with a sophisticated understanding of **financial and clinical analytics** will be best positioned for evolving payment models.
• **Stay ahead of the curve** and thoughtfully consider if certain voluntary programs are right for your practice
• Be aware of the changing landscape and **be ready to adapt to future mandated payment changes**
What physician practices can do now

- Expect MACRA implementation to proceed
  - Elections estimated to have limited impact
    - MACRA passed House 392-37; passed Senate 92-8

- Assess your performance under current programs
  - How did your group perform in PQRS and MU? Have you downloaded your 2014 Quality and Resource Use Report?

- Engage on ongoing learning about MACRA
  - Visit mgma.com/MACRA for more information and resources
  - Subscribe to the Washington Connection for updates about MACRA implementation

- Consider participating in an APM
Visit mgma.org/MACRA
2016 election
## 2016 election: Spotlight on Healthcare

<table>
<thead>
<tr>
<th>Bernie Sanders</th>
<th>Hillary Clinton</th>
<th>Ted Cruz</th>
<th>Donald Trump</th>
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<tr>
<td>Replace ACA with universal healthcare by expanding Medicare</td>
<td>Build on and modify existing ACA, including increasing exchange tax credits; addressing the “family glitch”; and creating a public option</td>
<td>Repeal ACA; replace with private insurance market that operates across state lines; institute health savings accounts</td>
<td>Repeal ACA; replace with private insurance market that operates across state lines; provide form of tax relief for insurance</td>
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</tbody>
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MGMA’s *Washington Connection* provides the latest in regulatory and legislative news straight from the nation’s capital and helps you stay one step ahead of evolving federal requirements and deadlines.

A variety of member-benefit webinars, articles, online tools and downloadable resources help you navigate complex federal programs and decipher need-to-know information.

Expert MGMA Government Affairs staff are available to answer questions and offer guidance on healthcare policy issues.
Use code…

GAMEM
Questions?
Appendix
Acronyms reference guide

- ACO – accountable care organization
- APM – alternative payment model
- CAHPS - Consumer Assessment of Healthcare Providers and Systems
- CMS – Centers for Medicare & Medicaid Services
- CNS – certified nurse specialist
- CPCI – Comprehensive Primary Care Initiative
- CRNA – certified registered nurse anesthetist
- EFT – electronic funds transfer
- EHNAC – Electronic Healthcare Network Accreditation Commission
- EIDM - Enterprise Identity Management
- EHR – electronic health record
- EP – eligible professional
- ERA – electronic remittance advice
- ESRD – end-stage renal disease
- GPCI – geographic practice cost index
- GPRO – group practice reporting option
- HHS – U.S. Department of Health & Human Services
- IACS - Individuals Authorized Access to the CMS Computer Services
- ICD-10 - 10th revision of the International Statistical Classification of Diseases and Related Health Problems
- MIPS – Merit-Based Incentive Payment System
- NPs – nurse practitioners
- NQS – National Quality Strategy
- PA – physician assistant
- PFS – physician fee schedule
- PM – practice management
- PQRS – Physician Quality Reporting System
- QCDR – qualified clinical data registry
- QRUR – quality and resource use report
- RVU – relative value unit
- VBPM – Value-Based Payment Modifier