Washington Update

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Agenda

- Political outlook and SGR
- ACA implementation
- New chronic care management service
- Federal quality reporting programs
- ICD-10 Implementation
Political Outlook and the Sustainable Growth Rate (SGR)
114th Congress: productive or partisan?

Key agenda items:

• Budget negotiations
• Sustainable growth rate (SGR) repeal

Spring recess: March 30 – April 10

Party Breakdown of 114th Congress

- 300 Republicans
- 232 Democrats
- 2 Independents
After years of struggle, is this the SGR’s fairy tale ending?
SGR repeal update

- Congress has enacted 17 SGR “patches” to avert cuts to physician payment at a cost of approx. $170 billion
- Current SGR patch expires on Mar. 31 and a 21.2% cut takes effect on Apr. 1, absent Congressional action
- An end to the SGR saga is in sight – but we need your help!
  - In an unprecedented display of bipartisan governance yesterday, the House of Representatives voted overwhelming (392-37) in favor of a bill to repeal the SGR
  - Senate left D.C. without taking up SGR repeal bill
  - **Tell** your senators that now is the time to repeal SGR once and for all. No more excuses, no more patches!
- MGMA sent a [letter of support](#) to key lawmakers
Overview of the SGR repeal bill

H.R. 2, The Medicare Access and CHIP Reauthorization Act

• Permanently repeals the SGR
• Replaces the SGR with stable fee schedule updates and incentives to move toward alternative payment models (APMs)
  – Period of stable annual updates:
    • Jan. 1 – June 30, 2015: conversion factor (CF) update is 0%
    • July 1, 2015 – Dec. 31, 2019: CF update is 0.5%
    • 2020-2025: CF update is 0%
  – 5% bonus is available to APM participants from 2019-2024
  – 2026 and beyond
    • 1.0% update for items and services furnished by an APM participant
    • 0.5% update for all other items and services
SGR repeal: H.R. 2

H.R. 2, MACRA

• Consolidates federal quality reporting programs into a single program, the Merit-Based Incentive Payment System (MIPS)
  – Goes into effect in 2019
  – Evaluates performance in four categories: quality, resource use, EHR meaningful use, and clinical practice improvement activities
  – Providers will have advanced notice of target composite score
  – Based on composite scores above or below the threshold, providers will receive Medicare bonuses or penalties

• Providers in APMs are excluded from MIPS
SGR repeal: H.R. 2

H.R. 2, MACRA

- Extends certain Medicare policies, including therapy caps exception and work GPCI floor
- Increases Medicare’s fraud and abuse fighting authority
  - Removes SSNs from Medicare cards and directs the Secretary to engage in other program integrity initiatives
- Reverses CMS’s decision to unbundle 10- and 90-day global surgical codes
- Estimated to cost $210 billion, generate $70 billion in revenue
  - Costs will be divided between Medicare beneficiaries and providers
- Full text of the bill and section-by-section summary
Affordable Care Act Implementation
Supreme Court to hear another ACA challenge

- *King v. Burwell* challenges the legality of IRS’s interpretation of ACA to provide subsidies for enrollees in federally-facilitated exchanges
- Oral arguments were heard in March; decision expected in June
- If Court rules that IRS cannot provide subsidies to consumers in 37 affected states, it could significantly undercut the ACA

**Employer mandate**

- Impacts businesses with 100+ employees in 2015 and businesses with 50+ employees in 2016.
- Penalizes employers who do not offer employees affordable health insurance coverage. Penalties vary based on the number of employees, coverage offered and whether employees receive premium tax credits through the ACA health insurance exchanges.

Learn more [here](#).
ACA Implementation 2015

• EFT and ERA operating rules in effect
  • You can opt out of virtual credit card payments (unless contracted)
  • EFT fees may not be “excessive”
  • MGMA EFT and ERA guide and sample letter for requesting EFT payments from health plans

• Sunshine Act, or “Open Payments”
  • 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
  • Last fall CMS released data for Aug. through Dec. 2013
  • Physician review and dispute period for 2014 data begins soon
  • MGMA resource: Open Payments: what you need to know
ACA Implementation 2015

- **Medicare Shared Savings Program (ACO)**
  - 89 new ACOs in 2015, bringing the total to 450 (7.2 mil. beneficiaries)
  - *Proposed changes* to program in Dec., response to participant concerns, MGMA comments
  - New “Next Generation” ACO model announced

- **Independent Payment Advisory Board (IPAB)**
  - 15-member panel tasked with identifying savings in Medicare
  - MGMA supports legislation that would repeal IPAB
  - Tell your member of Congress to repeal the IPAB
Chronic Care Management Service
Medicare Chronic Care Management Service (CCM)

• New Medicare non-face-to-face service (99490) for chronic care management for beneficiaries with multiple chronic conditions

• Requires at least 20 minutes of non-face-to-face services per calendar month, including care management services such as:
  – Creation/update of a comprehensive care plan
  – Assistance managing care transitions between healthcare settings
  – 24/7 access to the care management team for urgent chronic care needs
  – Coordination and communication with other health professionals outside the practice who are also involved in the patient’s care
Medicare Chronic Care Management Service (CCM)

• Before billing, practice must obtain written beneficiary consent (cost-sharing applies)

• Requires use of EHR certified to prior year’s MU criteria
  – Ex., for 2015, practices can use 2011 or 2014 edition CEHRT

• Requires remote 24/7 access to electronic care plan for care team
  – Must be used to share info electronically with providers outside practice

• MGMA Chronic Care Management Essentials resource

• CMS CCM Factsheet
Medicare Chronic Care Management Service (CCM)

Multiple (2+) chronic conditions expected to last 12 months or until the death of a patient

That place a significant risk of death, acute exacerbation/decomposition, functional decline

At least 20 minutes over a calendar month

Meet CCM criteria, such as establishing a comprehensive care plan

CPT 99490
$42.91
Federal Quality Reporting Programs
*EPs who were unsuccessful in MU and eRx will receive a 2% penalty in 2015.
“Meaningful Use” of Electronic Health Records Program
Meaningful Use in 2015

2014 was the last year to begin meaningful use and earn an incentive

<table>
<thead>
<tr>
<th>1st Year</th>
<th>Stage of Meaningful Use</th>
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<tbody>
<tr>
<td>2011</td>
<td>1</td>
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<tr>
<td>2012</td>
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<tr>
<td>2013</td>
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<td>2014</td>
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<td>2015</td>
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<td>2016</td>
<td>1</td>
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<tr>
<td>2017</td>
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</tbody>
</table>

Reporting period:

First-year participants:
- 90 consecutive days and to avoid the 2016 penalty, attest by Oct. 1, 2015

Returning EPs:
- entire calendar year (likely to change to 90 days)
Meaningful Use in 2015

Stage 1
- 13 core objectives
- 5 of 9 menu objectives
- 18 total objectives

Stage 2
- 17 core objectives
- 3 of 6 menu objectives
- 20 total objectives

To learn more:
- Meaningful Use: What MGMA Members Are Asking
- MGMA meaningful use resource center
- CMS Stage 1 vs. Stage 2 comparison table
- CMS educational materials
How to avoid 2016 Meaningful Use penalty

• 2016 meaningful use penalty: -2.0%
• Three ways to avoid the penalty:
  1. Successful meaningful user in 2014 and attested by March 20
  2. New meaningful user in 2015: demonstrate MU for 90 consecutive days and attest by Oct. 1
  3. Apply for a hardship exception by July 1
     • Infrastructure
     • New eligible professionals
     • Unforeseen circumstances
     • Lack of face-to-face or telemedicine interactions and follow-up visits with patients
     • EPs who practice at multiple locations and lack control over availability of the CEHRT for >50% of patient encounters

*Anesthesiology, radiology, and pathology are excluded from penalties and do not have to apply for a hardship exception
A look ahead: meaningful use changes

- MGMA has consistently advocated for added flexibility in meaningful use, including shortened reporting periods
  - On Jan. 29, CMS announced its intention to reduce physician burden through program modifications, including a 90-day reporting period in 2015
    - Changes will be made through a new rule, expected in the spring
- On Mar. 20, ONC and CMS released proposed requirements for MU Stage 3. Key changes include:
  - Stage 3 is optional in 2017, mandatory for all EPs in 2018
  - Establishes single reporting period of one calendar year for all EPs
  - Reduces number of objectives to 8 (incorporating 21 measures)
  - Read MGMA’s outline for more details about the proposed rule
Physician Quality Reporting System (PQRS)
2015 PQRS Overview

• Incentives are no longer available in PQRS
• Two year look-back for applying penalties
  – 2017 penalty will be based on 2015 reporting
    • 2017 PQRS penalty: -2% of Medicare Part B covered professional services
• Program requirements change annually
  – In 2015, to avoid a 2017 penalty:
    • EPs must report 9 quality measures covering 3 National Quality Strategy (NQS) domains for at least 50% of applicable patients
    • Group practices participating in group practice reporting option (GPRO) must register by June 30 and meet the reporting criteria
  – CMS retired and added many measures in 2015
    • Review the 2015 PQRS measures list and specifications to ensure accurate reporting
2015 PQRS individual reporting options

• 2015 individual eligible professional reporting options:
  – Claims, Registry, EHR, Qualified Clinical Data Registry

• No registration necessary

• In general, to avoid a 2017 -2% penalty:
  – EPs must report 9 quality measures covering 3 NQS domains for 50% of applicable patients
  – EPs who report via claims or registry and see at least one Medicare patient in a face-to-face encounter based on these codes must report at least one cross-cutting measure

• For more info, access 2015 PQRS Implementation Guide
2015 PQRS GPRO reporting options

• Group practice reporting option (GPRO): open to groups w/ 2+ EPs who reassigned their billing rights to TIN
• Groups must register to participate in GPRO via PV-PQRS portal between April 1 and June 30
• GPRO reporting options and notable changes for 2015:
  – Registry
    • Must report 1 cross-cutting measure if practice sees Medicare patient in face-to-face encounter
  – EHR
  – Web Interface (25+ EPs)
    • Report all web interface measures for 248 assigned patients
  – Certified Survey Vendor
    • Mandatory for groups with 100+ EPs that elect to report via GPRO
    • CMS will no longer pay to administer the survey
• For more info, access 2015 PQRS Implementation Guide
PQRS-Value Modifier Survival Guide

- Equip your practice with the resources and information you need to understand the VBPM and PQRS reporting options and requirements

- Access MGMA’s interactive PQRS-Value Modifier Survival Guide today!

MGMA developed this resource to help members understand participation requirements and options for the 2015 Physician Quality Reporting System (PQRS) and how this program interacts with the Value-Based Payment Modifier (VBPM). This member-benefit resource guides you through the various reporting mechanisms in PQRS and the requirements that accompany them. The guide also reviews criteria for avoiding penalties in the programs and provides assistance in understanding the critical connection between PQRS and the VBPM, which will impact all groups in 2017 based on 2015 performance.
Value-Based Payment Modifier (VBPM)
**What is the VBPM?**

- VBPM is a budget-neutral program that differentiates physician payment based on the cost and quality of care.
- Phased in over three years and impacts all physicians in 2017.

<table>
<thead>
<tr>
<th>Performance year</th>
<th>Modifier year</th>
<th>Impacted groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2015</td>
<td>groups w/ 100+ EPs</td>
</tr>
<tr>
<td>2014</td>
<td>2016</td>
<td>groups w/ 10+ EPs</td>
</tr>
<tr>
<td>2015</td>
<td>2017</td>
<td>all physicians</td>
</tr>
</tbody>
</table>

- In 2017, VBPM will apply to physicians in MSSP ACOs, pioneer ACOs, CPC Initiative, and other Innovation Center models.
- CMS intends to apply the VBPM to **all EPs** (ex. NPs, PAs) in 2018.
2017 VBPM: How it works

**In 2017, all groups of physicians and solo practitioners**

- **Satisfactory 2015 PQRS Reporters**
  - Register for GPRO or meet 50% individual EP reporting threshold
  - **AND** avoid the 2017 PQRS penalty

  **Mandatory Quality Tiering Calculation**
  - Groups of physicians with 2-9 EPs and solo practitioners
    - Upward or no adjustment based on quality tiering
  - Groups of physicians with 10+ EPs
    - Upward, neutral or downward adjustment based on quality tiering
      - -4% is the maximum downward adjustment for 2017

- **Non-Satisfactory 2015 PQRS Reporters**
  - Groups that do not meet PQRS criteria to avoid 2017 PQRS penalty
  - Groups of physicians with 2-9 EPs and solo practitioners
    - -2% modifier in 2017
      - In addition to -2% 2017 PQRS penalty
  - Groups of physicians with 10+ EPs
    - -4% modifier in 2017
      - In addition to -2% 2017 PQRS penalty
### 2017 VBPM scoring under quality tiering calculation

<table>
<thead>
<tr>
<th>Groups with 10+ EPs</th>
<th>Low cost</th>
<th>Average cost</th>
<th>High cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low quality</strong></td>
<td>0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
</tr>
<tr>
<td><strong>Average quality</strong></td>
<td>-2.0%</td>
<td>0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td><strong>High quality</strong></td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Groups with 2-9 EPs and solo practitioners</th>
<th>Low quality</th>
<th>Average quality</th>
<th>High quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low cost</strong></td>
<td>0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td><strong>Average cost</strong></td>
<td>0%</td>
<td>0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td><strong>High cost</strong></td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
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**VBPM quality tiering calculation:**

- “X” equals the VBPM adjustment factor
  - Determines the size of the bonus for higher-performing groups
  - Varies annually based on budget neutrality requirement
- Physicians are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25%
2017 VBPM: Next steps to prepare your practice

• Participate in PQRS in 2015:

  1. Register for and satisfactorily participate in 2015 PQRS GPRO, or

  2. Report PQRS measures via individual reporting option and at least 50% of EPs must avoid a 2017 PQRS penalty

    • Example: J&J Medical Group has 9 doctors and 1 NP, and all EPs report PQRS measures via claims. If at least 5 EPs avoid the 2017 PQRS penalty, then the entire group will avoid the 2017 VBPM penalty.

• Familiarize yourself with VBPM program requirements

• Access your 2013 QRUR reports
Quality and Resource Use Reports

QRURs include comparative performance data on cost and quality measures and preview outcome under VBPM

- In 2014, CMS released 2013 QRURs to many groups and solo practitioners
- CMS plans to release mid-year QRURs in April
- Access reports at CMS Enterprise Portal (using IACS log-in)
Take advantage of MGMA resources

Value-Based Payment Modifier

• The VBPM: [How to Prepare Your Practice](#)

• PQRS-Value Modifier [Survival Guide](#)

• General Medicare Update, [on-demand webinar](#)

• MGMA VBPM [resource center](#)

Quality and Resource Use Reports

• MGMA’s [QRUR resource webpage](#)
ICD-10 Implementation
Transition from ICD-9 to ICD-10

Compliance date: Oct. 1, 2015

• Steps practices should take now:
  – Inventory workflow and systems that could be impacted
  – Incorporate clinical documentation improvement
  – Determine EHR/PM software and other trading partner (coders, health plans, clearinghouses) readiness for transition
  – Take any opportunity to test with your trading partners, including clearinghouse, health plans, and CMS
ICD-10 testing opportunities with CMS contractors

- Acknowledgement Testing: MACs acknowledge whether ICD-10 claim was accepted or rejected
  - Providers can submit acknowledgement test claims at any time
  - Special acknowledgement testing week in June 2015
- End-to-end testing: MACs adjudicate claims and provide a remittance advice during three weeks in 2015
  - CMS released results from first end-to-end testing week. MGMA expressed concern to CMS about the low acceptance rate and limited testing opportunities.
  - To volunteer for last round of end-to-end testing (July 20-24), complete the application on your MAC’s website by April 17.

- Learn more here
MGMA ICD-10 resources:

- Comprehensive ICD-10 Preparation Guide
- ICD-10 Preparation Guide Part II
- Cypher ICD-10 Clinical Documentation Software
- ICD-10 Virtual Academy on-demand edition
- Find more tools and tips at MGMA’s ICD-10 Resource Center
Questions?
Sunshine Act or “Open Payments”

<table>
<thead>
<tr>
<th>Examples of Payments Reported</th>
<th>Examples of Payments NOT Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaking honoraria</td>
<td>Product samples for patients</td>
</tr>
<tr>
<td>Gifts</td>
<td>Educational materials for patients</td>
</tr>
<tr>
<td>Meals</td>
<td>Discount, including rebates</td>
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</tbody>
</table>

- CMS plans to release 2014 data later in 2015. Physician review/dispute period scheduled to open this spring.
- In 2016, reporting exemption for compensation for speaking at continuing medical education programs will be eliminated
- Also in 2016 - stock, stock options and any other ownership interests will have distinct reporting categories
- MGMA resources: [guide](#) and [memo](#)
How will you know if your EP is penalized in 2015?

- CARC 237 – Legislated/Regulatory Penalty, to designate when a meaningful use, PQRS, or Value-Based Payment Modifier penalty will be applied

- At least one Remark Code must be provided in combination with the following RARC:

<table>
<thead>
<tr>
<th>RARC</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS – N699</td>
<td>Payment adjusted based on PQRS</td>
</tr>
<tr>
<td>EHR – N700</td>
<td>Payment adjusted based on EHR Incentive Program (Meaningful Use)</td>
</tr>
<tr>
<td>VBM – N701</td>
<td>Payment adjusted based on Value-Based Payment Modifier</td>
</tr>
</tbody>
</table>
# PQRS leftovers from 2014

## 2014 PQRS data submission deadlines:

<table>
<thead>
<tr>
<th>Reporting method used in 2014</th>
<th>Submission Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR direct or data submission vendor</td>
<td>Mar. 20 at 8 pm ET</td>
</tr>
<tr>
<td>Qualified Clinical Data Registry (PQRS and CQMs for MU)</td>
<td>Mar. 20 at 8 pm ET</td>
</tr>
<tr>
<td>Group practice reporting option (GPRO) web interface</td>
<td>Mar. 20 at 8 pm ET</td>
</tr>
<tr>
<td>Qualified registries</td>
<td>Mar. 31 at 8 pm ET</td>
</tr>
<tr>
<td>QCDRs (PQRS only)</td>
<td>Mar. 31 at 8 pm ET</td>
</tr>
<tr>
<td>Maintenance of certification organizations</td>
<td>Mar. 31 at 8 pm ET</td>
</tr>
</tbody>
</table>
Calculating the 2017 VM score

What is the Value Modifier score composed of?

1) **Quality measures**
   - PQRS GPRO measures or individual measures reported by 50% of EPs

2) **Outcomes measures**
   - Acute condition composite – measures potentially preventable hospital readmissions for three acute conditions (dehydration, bacterial pneumonia, urinary tract infection)
   - Chronic condition composite – potentially preventable hospital readmissions for three chronic conditions (diabetes, heart failure and COPD)
   - All-cause hospital readmission measure if 200+ patients are assigned

3) **Cost measures**
   - Total per capita cost (includes Part A and Part B spending), per capita cost for 4 chronic conditions (COPD, coronary artery disease, diabetes, heart failure), and Medicare Spending Per Beneficiary
   - Risk adjusted and standardized to eliminate geographic variation
   - Adjusted for specialty mix of the EPs within the group
Additional changes to VM program

• Changes to VM patient attribution methodology
  – CMS will include NPPs (PAs, NPs, and CNSs) in first step of attribution methodology and will remove “pre step”
  – Revised patient attribution methodology:
    • Step 1: beneficiaries assigned based on plurality of primary care services provided by primary care physician or NPP
    • Step 2: beneficiaries not assigned in Step 1 are attributed based on plurality of primary care services provided by physicians and NPPs of any specialty

• Starting in 2015, VM will only be applied to assigned services
• Deadline to request correction to 2015 VM: Feb. 28, 2015
  – In future years, deadline will be 60 days after release of QRURs
• 2018 VM will apply to non-physician providers, including PAs, NPs, CNSs, therapists, and more