Washington Update
Tennessee MGMA – August 24, 2012

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Agenda

• Current political landscape
• ACA ruling
• Sustainable Growth Rate (SGR) formula
• Medicare payment issues
• Federal quality programs
• Compliance
2012 Political Outlook

- Expect Washington gridlock to increase
- 2012 elections
- ACA battle will continue to wage as we see continued implementation of the ACA

SCOTUS ruling on the ACA

- The Patient Protection and Affordable Care Act was upheld by the Supreme Court of the United States
- Mandate upheld under Congress' taxing authority
- Medicaid expansion: states have choice
- Variability in state implementation of Medicaid expansion
ACA Implementation

- 2013-2014 Medicaid/Medicare payment parity for E&M services and immunizations – proposed rule and fact sheet
- 2014 Medicaid expansion
- 2014 state implementation of state-based Exchanges
- Numerous regulations still coming out
- Modification and repeal of certain provisions
- Independent Payment Advisory Board (IPAB): 2015

Longer-Term ACA Payment Reforms

- Medicare Shared Savings Program (ACO): 2012
- National pilot program on payment bundling: 2013
- Value-based payment modifier: 2015
- Centers for Medicare & Medicaid Innovation (CMMI)
  - Advanced Payment ACO model
  - Bundled Payment for Care Improvement Initiative
  - Others… For more information visit: [http://www.innovations.cms.gov](http://www.innovations.cms.gov)
Sustainable Growth Rate (SGR)

- Congress averted the 27.4% cut for 2012
- 10 month extension through December of this year
- CMS estimates a 27.4% cut for 2013
- **MGMA position – repeal the flawed SGR**

Budget Control Act & 2013 Sequester Cuts

- **BCA will trigger Sequester Cuts: across-the-board spending cuts for fiscal years 2013-2021 to achieve $1.2 trillion in savings**
  - Medicare program is capped at reductions of 2%
    - 2% represents a $123 billion cut over 10 years
- **Measures introduced in Congress to avert sequestration**
Medicare Payment Issues

2013 Medicare proposed fee schedule

- Sets payment rates for CY 2013 for physician services
- Continues implementation of the physician value-based payment modifier (Value Modifier) included in the Affordable Care Act
- Adopts changes to the Physician Quality Reporting System (PQRS) and the Electronic Prescribing (e-prescribing) Incentive Programs
- Includes additional Multiple Procedure Payment Reductions (MPPR)
- Proposes a separate payment for post-discharge care management services
- MGMA has released an analysis and will provide comments to CMS
Proposed PQRS changes

- Report on 1 measure or 1 measures group to avoid 2015-2016 penalty (claims, administrative claims, registry or EHR)
- Expanded group reporting - GPRO (2-25 EPs)
- New reporting option
  - Administrative Claims
- Will be cornerstone for the Value-Based Payment modifier
  - GPRO reporting non-optional for groups with 25 or more EPs for value modifier
  - GPRO Web Interface reporting non-optional for groups with 100 or more EPs for value modifier

Proposed VBP Modifier

Groups with 25 + EPs

- Satisfactory PQRS Reporters
  - Meet the 2013 criteria for satisfactory PQRS group reporting using GPRO: web-interface, claims, registries, EHRs, or administrative claims
  - 0% Modifier for 2015
    - (No Payment Adjustment)

Non-Satisfactory PQRS Reporters

- Groups that do not meet PQRS criteria for 2013
- -1% Modifier for 2015
  - In addition to the -1.5% PQRS penalty for 2015

Elect Quality-Tiering

- Groups could (1) earn an upward payment adjustment for high performance OR (2) risk a downward adjustment for poor performance
- 2015 Modifier will Adjust
  - Either Upward or Downward
  - -1% would be the maximum downward adjustment for 2015
Proposed eRx program changes

- Two newly proposed hardship exemptions for certain providers who have registered or attested for the meaningful use program
  - To use these exemptions to avoid the 2013 penalty, be prepared to act quickly!
- Addition of an informal review, or appeals process
  - Appeal the 2013 incentive decision
  - Appeal the 2013 or 2014 payment adjustment
- Changes to GPRO reporting option criteria

PPFS MPPR and Primary Care Discharge

- Multiple Procedure Payment Reduction (MPPR)
  - CMS proposes to apply a MPPR to the technical component of certain cardiovascular and ophthalmology diagnostic procedures
  - MPPR would reduce the second and subsequent procedures by 25% when furnished by the same physician (or group) to the same patient on the same day
- CMS proposes new G-code for non face-to-face post-discharge care management
  - For services provided 30 days after stay in hospital, SNF, community mental health center
  - Proposed payment is between Level 3 and Level 4 established patient office visit
### Federal Quality Programs

### Entering the penalty phase

<table>
<thead>
<tr>
<th>Year/Program</th>
<th>eRx</th>
<th>PQRS</th>
<th>Meaningful Use</th>
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</thead>
<tbody>
<tr>
<td>2012</td>
<td>1.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>1.5%</td>
<td></td>
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<tr>
<td>2014</td>
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<td></td>
</tr>
<tr>
<td>2015</td>
<td>1.5%</td>
<td>1.0%</td>
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<tr>
<td>2016</td>
<td>2.0%</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>2017 - 2019</td>
<td>2.0%*</td>
<td>3.0%</td>
<td>(each year)</td>
</tr>
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* PQRS is currently only scheduled through 2016, but if extended, the penalties would remain at 2% for additional program years.
Avoiding 2014 eRx Penalty

Two reporting period options:
• 6 month reporting (Jan. 1 – June 30, 2013)
  – report via claims based reporting only
  – not restricted to reporting in association w/ an eligible patient visit code (denominator code), must report with a payable service
• Full year reporting (successful e-prescriber in 2012)
  – report via claims, EHR or registry

Providers who are not penalized:
– New providers
– EPs who have a low level of Medicare claims from the denominator set of codes (fewer than 100 claims or less than 10% of Medicare allowed charges)

Avoiding 2014 eRx Penalty

• Hardship exemptions:
  – Unable to prescribe due to local, State or Federal law or regulation
  – Prescribed fewer than 100 times during a respective 6 month reporting period
  – Providers practicing in areas with limited high-speed Internet (G8642)
  – Providers practicing in areas with limited pharmacies with eRx capabilities (G8643)

• Quality Reporting Communication Support Page User Manual
• MGMA eRx resources
E-prescribing Program

E-prescribing Bonus 2012 – 2013
- EP must submit 25 instances of e-prescribing during the calendar year
  - 2012: 1% bonus
  - 2013: .5% bonus
- Report G code G8553 using claims, registry, or EHR
- Must have 10%+ of Medicare allowed charges from denominator codes

Denominator Code List:
90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

Physician Quality Reporting System (PQRS)
- Incentive 2012 - 2014: 0.5% bonus
  - Additional 0.5% for also participating in the Maintenance of Certification Program
- Can report on individual measures or measures groups
- Penalties begin in 2015 (1.5%) based on 2013 PQRS
- PQRS data will be cornerstone of VBP modifier
EHR Incentive Program (CMS/ONC)

- Meeting **Stage I** core and menu set [MU measures](#)
  - 15 core measures
    - 6 clinical quality measures (choose 3 core/alternate core + 3 menu set)
  - Choose 5 of 10 menu set measures

Meaningful Use Stage 2

- Stage 2 [final rule](#) released Aug. 23, along with [factsheet](#)
- Stage 2 delayed until 2014
  - 3 month reporting period in 2014 for EPs reporting under Stage 2 requirements
- Eliminates or combines some Stage 1 objectives, adds new requirements
- EPs must report 20 measures (17 core / 3 out of 6 menu)
- Must report clinical quality measure data electronically, starting in 2014
- Four hardship exemption categories for penalties beginning in 2015
Compliance

Medicare Enrollment: Ordering/Referring

- Revised ordering/referring requirements, “Phase 2” to come
- Applies to ordered/referred DMEPOS, home health claims, clinical lab and imaging services
- Ordering/referring provider must:
  - Have an enrollment record in Medicare, be of a specialty that is eligible to order/refer in Medicare and have their legal name and NPI listed on the furnishing physician’s claim
- CMS currently issues warnings for failing to meet the criteria
  - Check CMS Ordering Referring Report
- Must maintain documentation on orders for 7 years
Medicare Enrollment

- CMS will revalidate all Medicare providers by **March 2015**
  - Respond to revalidation request within 60 days
  - Learn more: CMS MLN Matters [Article on Revalidation](#)
- Physicians can now submit Medicare enrollment applications 60 days before the effective date
- Ongoing MGMA advocacy to improve PECOS
  - New features: electronic signature, fast track view option, online EFT enrollment, digital document upload capability, etc.
- Learn more at [http://www.mgma.com/PECOS/](http://www.mgma.com/PECOS/)

Recovery Audit Contractors (RACs)

**Purpose:** Identify and recoup overpayments and refund underpayments in federal healthcare programs

- Part B RAC activity is increasing

**MGMA Advocacy and Resources**
- New member benefit: [RAC Appeals Navigator](#)
- [MGMA RAC Resource Center](#)
- Monitoring member RAC experiences through [RACWatch@mgma.com](mailto:RACWatch@mgma.com)
5010 and ICD-10

• Healthcare industry must transition from ICD-9 to ICD-10 by Oct. 1, 2013
  – CMS released proposed rule to push back the date again, until Oct. 1, 2014
• To date the government has failed to meet MGMA criteria: demonstrate how the benefits outweigh significant costs, pilot test the new code set, and consider alternative approaches

Advocacy - Get Involved!

MGMA Advocacy Initiatives

• Advocacy priorities:
  – Repeal the SGR
  – MGMA Congressional Site Visit Campaign
    ➢ Visit mgma.com/site-visit/ for resources and helpful information for setting up a site visit
Thank you!

Q&A

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