Washington Update

Presented by MGMA Government Affairs

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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
CONNECT for Health Act *(S 2484/HR 4442)*

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

**Action Steps >>**

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

> **MGMA resource:** [Medicare Revalidation Cycle 2: What you need to know](#)

**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

**Part D:** Deadline for enrolling in/opting out of Medicare for Part D prescribing recently extended to **Aug. 1**
HIPAA

Phase 2 audits: Two types of audits:

- **“Desk” audits:** (most common) Notified via email; have 10 business days to submit requested info to OCR via online portal
- **On-site audits:** Auditors spend 3-5 days on site; “more comprehensive”
  May trigger OCR compliance review if serious issues are discovered

**Action Steps >>**
(1) Check spam folder for OCR emails
(2) Access MGMA’s [MU FAQs & Security Risk Analysis Toolkit](https://www.mgma.com)

“Unreasonable fees”: Lookout for increasingly common "virtual credit cards" or “value-add service fees” to EFT payments (1-3%)

**Action Steps >>**
(1) Utilize MGMA’s [EFT/ERA Guide](https://www.mgma.com) and [sample letter](https://www.mgma.com) for requesting EFT payments
(2) Stand firm against fees to health plans (cite HIPAA regulations)
(3) Lodge formal complaint directly with [OCR](https://www.hhs.gov/ocr) or through [MGMA](https://www.mgma.com)
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*

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Meaningful Use</th>
<th>PQRS</th>
<th>VBPM*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practices of 10+ EPs</td>
<td>3-4%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Maximum:</td>
<td>-10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practices of 9 or fewer EPs</td>
<td>3-4%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Maximum:</td>
<td>-8%</td>
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</tbody>
</table>

*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.
- QCDR reporting is now available under GPRO
- GPRO registration deadline: **June 30**
VBPM

(Value-Based Payment Modifier)
• **Step 1: Automatic penalty or quality tiering adjustment?**
  - Unsuccessful PQRS reporters > -2% to -4% automatic penalty
  - Successful PQRS reporters > -4% to +4x quality-tiering adjustment

• **Step 2: Calculate practice’s total composite score**

<table>
<thead>
<tr>
<th>Quality Composite Score (50%)</th>
<th>Cost Composite Score (50%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- PQRS measures</td>
<td>- Per capita cost</td>
</tr>
<tr>
<td>- Preventable hospital</td>
<td>- Medicare spending per beneficiary</td>
</tr>
<tr>
<td>admissions/readmissions</td>
<td>- Per capita cost for chronic conditions</td>
</tr>
</tbody>
</table>

• **Step 3: Compare to national average & adjust payments**

<table>
<thead>
<tr>
<th>9 EPs or fewer</th>
<th>Low quality</th>
<th>Avg. quality</th>
<th>High quality</th>
<th>10 or more EPS</th>
<th>Low quality</th>
<th>Avg. quality</th>
<th>High quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost</td>
<td>0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
<td>Low cost</td>
<td>0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
</tr>
<tr>
<td>Average cost</td>
<td>- 1.0%</td>
<td>0%</td>
<td>+1.0x*</td>
<td>Average cost</td>
<td>- 2.0%</td>
<td>0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>High cost</td>
<td>- 2.0%</td>
<td>- 1.0%</td>
<td>0%</td>
<td>High cost</td>
<td>- 4.0%</td>
<td>- 2.0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
2016 VBPM Payment Adjustments
Based on 2014 cost and quality data

13,813 groups of 10+ EPs are impacted

- **39.2%** (5,418 practices) auto -2% penalty
- **59.4%** (8,208 practices) Neutral QT adjustment
- **0.9%** (128 practices) QT bonus of +15.92% or +31.84%
- **0.4%** (59 practices) QT penalty of -1% or -2%

Source: CMS’ fact sheet on 2016 VBPM results
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 Step:**

1. Download your 2014 final and 2015 mid-year QRURs (just released in April) from the [CMS Enterprise Portal](https://www.cms.gov).
2. Stay tuned to the *Washington Connection* for news about your 2015 final QRURs, expected sometime this Fall.
3. Visit mgma.org/QRUR for more information.
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 EPs
- MGMA actively pursuing 90-day reporting period for 2016

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
How are quality reporting adjustments applied?

<table>
<thead>
<tr>
<th>PQRS</th>
<th>VBPM</th>
<th>MU</th>
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</thead>
<tbody>
<tr>
<td>Unique NPI/TIN combination</td>
<td>TIN (practice) level</td>
<td>NPI (provider) level</td>
</tr>
<tr>
<td>Adjustment is not applied if NPI/TIN</td>
<td>Adjustment stays with practice</td>
<td>Adjustment follows provider</td>
</tr>
<tr>
<td>combination no longer exists</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*MGMA resource:*

How Medicare penalties apply to providers who switch practices
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](#)
MACRA
(Medicare Access and CHIP Reauthorization Act)
MACRA: A Two Pathway Model

Sunset in 2018

- PQRS
- Value-Based Payment Modifier
- Meaningful Use

Start in 2019

MIPS
(Merit-Based Incentive Payment System)

OR

APMs*
(Alternative Payment Models)

* “Non-qualifying” APMs will receive “favorable scoring” in MIPS
MIPS
MIPS: What we know from MACRA Payments

- Budget neutral aka dual sided risk
- Maximum penalties:
  - 4% in 2019
  - 5% in 2020
  - 7% in 2021
  - 9% in 2022 onward
- Additional $500 million in payouts for “exceptional performance”*

* Exempt from budget neutrality requirement
MIPS: What we know from MACRA

**Scoring**

- Single composite score based on 4 performance categories:
  1. Quality (50% in 2019)
  2. Resource Use (10% in 2019)
  3. Clinical Practice Improvement Activities (15% in 2019)
  4. Use of EHR technology (25% in 2019)

- Weights change over time

- Scores evaluated using some sort of “linear sliding scale” methodology
MIPS: What we know from MACRA

Eligible Professionals

- Applies to Medicare Part B clinicians
  - Physicians
  - Physician assistants
  - Nurse practitioners
  - Clinical nurse specialists
  - Certified, registered nurse anesthetists

- Exempted from MIPS if:
  - Newly enrolled in Medicare
  - Doesn’t meet low-volume threshold requirements (established by Secretary)
  - Is a qualifying or partially qualifying APM participant
APMs
APMs: What we know from MACRA

Definition

Under MACRA, “eligible” APMs must:

- Base payment on quality measures comparable to MIPS
- Require use of certified EHRs
- Bear more than “nominal financial risk” (left undefined) or be a medical home model

Examples of APMs given in MACRA:

- Medicare Shared Savings Program ACOs
- Patient-centered medical homes
- CMS Innovation Center Models
- Other federal demonstrations
Qualifying participants in “eligible” APMs receive:

- Exemption from MIPS
- 5% annual lump sum bonus payments through 2023
- 0.5% higher fee schedule update from 2026 onward

To earn incentives, an increasing share of a participant’s payments must be attributable to services furnished through the APM entity:

- **2019-2020** = 25% of Medicare $$
- **2021-2022** = 50% of Medicare $$ OR 50% of overall $$ including 25% of Medicare $$
- **2023 onward** = 75% of Medicare OR 75% of overall $$ including 25% of Medicare $$

*Secretary may also establish patient thresholds using similar % criteria*
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
PROPOSED RULE
ON MIPS AND APMS
MIPS & APMs Proposed Rule

- MACRA is only a framework (95 pages)
- Federal agencies have substantial discretion in implementation via the rulemaking process ("Secretary" mentioned over 300 times in law)
- On April 27, CMS released the highly-anticipated MIPS and APMs proposed rule (962 pages)
MIPS & APMs Proposed Rule

Timing Takeaways

- Full calendar reporting year
- 2-year lookback between performance and payment years
- Jan. 1, 2017 start date

MGMA concerns:
- Comment period and final rulemaking process still to go, leaves very limited time for industry preparation including practice education and updates to vendor technology
- Disconnect between performance and payment limits practices’ ability to correct reporting issues in real time and improve quality based on actionable feedback
MIPS & APMs Proposed Rule

MIPS Takeaways

• Resemblance to current programs
• Still elements of all-or-nothing scoring in EHR use category
• Each category has its own distinct scoring methodology and point system
• Various exceptions and reweighting of performance categories depending on participation in various models, APM designation, etc.

MGMA concerns:

• CMS proposes additional stipulations and layers of complexity beyond what is included in the original statute that adds unnecessary confusion to MIPS scoring.
MIPS & APMs Proposed Rule

APMs Takeaways

• Qualify for incentive $$$ and exemption from MIPS only by “significantly participating”* in an “advanced APM”
  *2019 threshold: 25% Medicare payments OR 20% Medicare patients

• CMS will notify new APM applicants of status after start of MIPS performance year; all groups must report MIPS in 2017.

• 2017 qualifying models:
  - Comprehensive Primary Care Plus
  - Oncology Care Model with two-sided risk
  - Comprehensive ERSD Care
  - Next Generation ACOs
  - MSSP ACOs – Tracks 2 & 3

MGMA concerns:

• Proposed definition is significantly too narrow

• No advance guarantee and harsh cutoff with little credit should a group come up shy of threshold could act as a disincentive
Next Steps for MGMA

• Currently reviewing proposed rule
• Keeping members informed.
  – Check mgma.org/MACRA for breaking updates
  – Stay tuned for June advocacy webinar!
• Gathering intel
  – CMS
  – industry coalitions
  – Member perspective via government affairs council & other means
• Will submit comments by June 27 deadline

>> Final rule expected this fall
• Will issue a comprehensive analysis of the final rule with everything our members need to know
What physicians practices can do now

✓ Remember this rule is PROPOSED
✓ Expect MACRA implementation to proceed
  ▪ Passed by wide margins in House and Senate
✓ Assess your practice’s performance under current quality reporting programs
  ▪ Many consistencies heading into MIPS
✓ Consider whether participating in an APM could be a viable option for your practice
✓ Engage in ongoing learning about MACRA
  ▪ Subscribe to the *Washington Connection* for the latest implementation information and tools and resources
  ▪ Visit mgma.org/MACRA
MACRA

BREAKING:

The Centers for Medicare & Medicaid Services released the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models proposed rule on April 27, 2016:

- Proposed rule (released on April 27, 2016)
- HHS press release (released on April 27, 2016)
- HHS Executive Summary (released on April 27, 2016)
- MIPS & APMs proposed rule fact sheet (released on April 28, 2016)
- Proposed MIPS EHR component fact sheet (released on April 28, 2016)
- Register for the May 3 CMS webinar: Overview of the MIPS & APMs proposed rule (announced on April 29, 2016)
- Register for the May 4 CMS webinar: Review of proposed MIPS program (announced on April 29, 2016)

What is MACRA?

After 17 years of uncertainty and threats of drastic cuts to physician payments, the flawed sustainable growth rate (SGR) formula was finally repealed in 2015 by the Medicare Access and CHIP Reauthorization Act (MACRA). But that was just the starting point. MACRA established a new future for Medicare payments, including two separate pathways toward quality-based reimbursement and a period of positive, stable Medicare payment updates.

Key elements of MACRA include:
And then there’s...
The 2016 election
## 2016 election: Spotlight on Healthcare

<table>
<thead>
<tr>
<th>Candidate</th>
<th>Position and Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bernie Sanders</strong></td>
<td>Replace ACA with universal healthcare by expanding Medicare</td>
</tr>
<tr>
<td><strong>Hillary Clinton</strong></td>
<td>Build on and modify existing ACA, including increasing exchange tax credits; addressing the “family glitch”; and creating a public option</td>
</tr>
<tr>
<td><strong>Donald Trump</strong></td>
<td>Repeal ACA; replace with private insurance market that operates across state lines; provide form of tax relief for insurance</td>
</tr>
</tbody>
</table>
Let MGMA guide you to success.

Benefits of MGMA Government Affairs

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.
Questions?
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