Washington Update

Presented by MGMA Government Affairs

Suzanne Falk
sfalk@mgma.org
Associate Director, Government Affairs
Agenda

- HIPAA Updates
- CY 2017 Proposed Medicare Physician Fee Schedule
- Federal Quality Reporting Programs in 2016
- Medicare Access and CHIP Reauthorization Act (MACRA)
- MIPS and APMs Proposed Rule
- 2016 Elections and Political Outlook
HIPAA Updates

Phase 2 audits: Ongoing since March 2016; two types:

• **Desk audits**: 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”


**Action step**: Check spam for emails from OSOCR Audit@hhs.gov

Virtual credit card & EFT service fees: average 1-3%; HIPAA prohibits “unreasonable” transaction fees

MGMA resources: [EFT/ERA Guide](https://www.mgma.com/resources/privacy-security/eft-ERA-guide); [Sample Letter](https://www.mgma.com/resources/privacy-security/sample-letter) to request EFT $$

**Action steps:**

- Request an EFT payment
- Stand firm against fees; Cite HIPAA regulations
- Lodge a formal complaint with OCR or through MGMA
Proposed CY 2017 Medicare Physician Fee Schedule
Overview

Proposed CY 2017 Physician Fee Schedule

Timeline:
- Proposed rule was released on July 7
- MGMA plans to submit comments, which are due Sept 6
- Final rule expected by Nov 1

Conversion Factors:
- Table 41 displays the calculation behind the CY 2017 CF

<table>
<thead>
<tr>
<th>Conversion Factor in effect in CY 2016</th>
<th>35.8043</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update Factor</td>
<td>0.50 percent (1.0050)</td>
</tr>
<tr>
<td>CY 2017 RVU Budget Neutrality Adjust</td>
<td>-0.51 percent (0.9949)</td>
</tr>
<tr>
<td>CY 2017 Target Recapture Amount</td>
<td>0 percent (1.0000)</td>
</tr>
<tr>
<td>CY 2017 Imaging MPPR Adjustment</td>
<td>-0.07 percent (0.9993)</td>
</tr>
<tr>
<td>CY 2017 Conversion Factor</td>
<td>35.7751</td>
</tr>
</tbody>
</table>
Key Takeaways

Proposed CY 2017 Physician Fee Schedule

• Would require providers and suppliers to be enrolled in Medicare in order to contract with MA health plans

• Continues implementation of appropriate use criteria for diagnostic imaging

• Establishes how VM payment determinations would change after informal review or if unanticipated data issues arise

• Proposes various coding and payment changes, including:
  - **New reimbursable codes** for treating dementia, behavioral health conditions, prolonged E&M services, and patients with limited mobility
  - **Billing changes to CCM services** to reduce administrative burden and provide additional reimbursement for treating complex cases
Visit:
mgma.org/Medicare-reimbursement

- 2016 Medicare Physician Fee Schedule Analysis
- 2016 Medicare Update Free On-Demand Webinar

*Stay tuned for the 2017 Proposed PFS Analysis and other CY 2017 tools and resources!
Federal quality reporting programs in 2016
### Total Medicare payments at risk

#### Current Federal Quality Reporting Programs

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

<table>
<thead>
<tr>
<th>Practice of 9 or fewer EPs</th>
<th>Meaningful Use</th>
<th>PQRS</th>
<th>VBPM*</th>
<th>Maximum</th>
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<td>-7%</td>
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</table>

*There are equivalent bonuses available under the Value-Based Payment Modifier.*
PQRS in 2016

*Current Federal Quality Reporting Programs*

- **2% automatic penalty** in 2018 for failing to report in 2016
- **Most** reporting options require **9** quality measures that span at least **3** NQS domains
  - Plus **cross-cutting measure requirement** for claims & registry
- Measures have changed in 2016 so make sure to view the **2016 PQRS measures list**
- GPRO registration deadline was June 30; providers may still report as individuals
Value-Based Payment Modifier in 2016

Current Federal Quality Reporting Programs

• Requires no separate reporting; CMS analyzes cost and quality performance from claims and PQRS data
• Pay for performance; potentially adjusts payments based on how a group’s cost & quality performance compares nationally
• Gradually expanded over time…
  – Now applies to all physicians, PAs, NPs, CNSs & CRNAs
  – All size groups now subject to “quality-tiering” penalties
• Evaluated at TIN level; practices must report PQRS data successfully as a group through the GPRO or have at least half of the EPs in the practice report successfully as individuals
• TIN exempted if 1 or more EPs participates in one of the following models: Oncology Care Model; Next Gen ACOs; Pioneer ACOs; Comprehensive ESRD Care Initiative; CPCI
VM Methodology: Step 1
Current Federal Quality Reporting Programs

Automatic penalty or quality-tiering adjustment?

Practice did NOT successfully report PQRS data

Practice successfully reported PQRS data

10 or more EPs  |  9 or fewer EPs  |  Non-physician EPs only

Automatic VM Penalty
-4%  |  -2%  |  -2%

Quality-Tiering $$ Adjustment
-4x to +4x  |  -2x to +2x  |  0 to +2x
Calculate composite scores for cost and quality

- Patients are attributed to TINs where they received a plurality of their primary care services
- Measures that meet case thresholds will be scored, risk- and specialty-adjusted and count towards composite scores

### Quality Composite Score (50%)
- PQRS measures
- Preventable hospital admissions/readmissions

### Cost Composite Score (50%)
- Per capita cost
- Medicare spending per beneficiary
- Per capita cost for certain chronic and acute conditions
VM Methodology: Step 3
Current Federal Quality Reporting Programs

Determine quality-tiering payment adjustment based on how composite scores compare to national averages

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

<table>
<thead>
<tr>
<th>Practices with 9 or fewer EPs or non-physician EPs only*</th>
<th>Low quality</th>
<th>Average 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>
</tr>
<tr>
<td>Average cost</td>
<td>-1.0%</td>
<td>0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High cost</td>
<td>-2.0%</td>
<td>-1.0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Not subject to quality-tiering penalties

“X” = payment adjustment factor
- Determines size of bonuses annually based on cumulative penalties
- Additional 1x if average beneficiary risk score is in top 25%
2016 VM Payment Adjustments

Current Federal Quality Reporting Programs

13,813 groups of 10+ EPs are impacted based on 2014 data

- **0.9%**
  - (128 practices)
  - QT bonus of +15.92% or +31.84%

- **39.2%**
  - (5,418 practices)
  - auto 2% penalty

- **0.4%**
  - (59 practices)
  - QT penalty of -1% or -2%

- **59.4%**
  - (8,208 practices)
  - Neutral QT adjustment

Source: CMS’ [fact sheet](#) on 2016 VBPM results
Your VBPM report card!

Available for download from the CMS Enterprise Portal.

2014 Final QRURs
- Includes practice-specific cost and quality metrics and performance respective to national averages
- Provides payment adjustment info

2015 Mid-Year QRURs
- Informational progress report
- Excludes PQRS quality data!

*2015 Final QRURs coming this fall!

Visit: mgma.org/QRUR
Meaningful Use in 2016

Current Federal Quality Reporting Programs

Reporting period

- Full-year reporting in 2016, with a limited exception for new EPs
- ! Proposed CY17 OPPS rule includes 90-day EHR reporting in 2016 !

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

- Previously 17 core and 3 menu objectives
- Redundant/“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)

Increased transparency of EHR products

- New gov website publicly discloses cost and performance limitations of health IT products and services
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
Law is passed requiring rulemaking → Department issues a proposed rule → Public Comment Period → Department reviews comments, makes modifications → Department issues final rule
MACRA

Shaping the future of quality reporting

Current programs

- Meaningful use
- Value-based payment modifier
- PQRS

MIPS

- Advancing care information (ACI)
- Resource use (aka Cost)
- Quality
- Clinical practice improvement activities

Meaningful use

Value-based payment modifier

PQRS

Cost

Quality

New
**MACRA**

*Quality reporting: Then and now*

**PQRS, VBPM, MU**

- Max cumulative penalties of up to 9% in 2018
- Scores evaluated on all-or-nothing basis
- No budget neutrality requirements; only VBPM features upside risk
- 3 separate programs

**MIPS**

- Max penalty of 4% in 2019
- Scores must be evaluated on a “sliding scale”
- Program must be budget neutral and feature dual-sided risk*
- 1 program with 4 performance categories…

* Does not include extra “exceptional performance” bonuses in 2019-2024
MACRA
MIPS performance category weights in 2019

Quality 50%

Advancing Care Info (EHR Use) 25%

CPIA 15%

Cost 10%

*CMS has broad authority to reweight these categories and weights change over time
In 2017-2018, eligible clinicians (ECs) include:
- Physician
- Physician assistant
- Nurse practitioner
- Certified nurse practitioner
- Certified registered nurse anesthetists

The following types of ECs would be excluded from MIPS:
- Qualifying APM participant
- Partially qualifying APM participant who opts out of MIPS
- Newly-enrolled in Medicare
- Does not exceed low volume threshold

^ CMS proposes to set at ECs or groups that have $10,000 or less in Medicare spending and 100 or less Medicare patients
MACRA

Why should I become an APM?

• Qualifying participants in eligible APMs get:
  • Exemption from MIPS;
  • 5% annual lump sum bonus payments through 2024; and
  • A 0.5% higher fee schedule update from 2026 onward.

• Partially qualifying participants in eligible APMs get:
  • The option to forego participating in MIPS.
  • Favorable scoring in MIPS.
Step 1: Participate in an “eligible” APM model, which must:
- Base payment on quality measures comparable to MIPS;
- Use certified EHRs; and
- Bear more than “nominal financial risk” (left undefined)  
  ...OR be a medical home model.

Step 2: “Significantly participate” in the APM, which in 2019-2020 means practices must meet the following % thresholds:
- At least 25% of Medicare $$ or 20% of patients* must flow through an APM to be a fully qualifying APM participant.
- At least 20% of Medicare $$ or 10% of patients* must flow through an APM to be a partially qualifying APM participant.

* Patient threshold was established in proposed MIPS/APMs rule
MACRA
The Future of Medicare Payments

Baseline PFS Updates


0.5% 0% 0.25%

MIPS*

±4% ±5% ±7% ±9%

+10% exceptional performance bonus*

APMs

5% lump sum bonus

0% +0.5% PFS

*Potential 3x scaling adjustment but unlikely
** Up to $500 million/year
MIPS and APMs

proposed rule
On April 27, CMS released a major proposed rule to implement the MIPS and APMs provisions of MACRA.
MIPS & APMs Proposed Rule

MIPS timing takeaways

- Jan. 1, 2017 start date
- Full calendar reporting year
- 2-year lookback between performance and $$ years
- Feedback on an annual basis
MIPS & APMs Proposed Rule

**MIPS Takeaways**

- **Not simplified.** Total points & scoring methodology vary by performance category.

- **Not streamlined.** Up to 69 total measures required; dramatic increase in certain reporting thresholds; and no opportunity to earn credit across performance categories.

- **Not new.** Measure benchmarks based on data 4 years prior to payment year and numerous flawed past policies reused (e.g. measures reliant on 3rd party action and faulty patient attribution methodology from Value-Modifier).
200+ measures to choose from

ECs and groups report 6 measures, down from 9 in PQRS
- Must include one outcome and one cross-cutting measure

Each measure worth up to 10 points based on performance relative to benchmarks

For groups with 10 or more ECs, CMS will also calculate 3 population-based measures using claims

Substantially increased reporting thresholds
- Claims: 80% of all Medicare Part B patients
- Registry, EHR, QCDR: 90% of all patients (all payers)
- Web interface: 248 assigned patients (same as PQRS)
MIPS & APMs Proposed Rule

**MIPS: Resource use (aka cost)**

<table>
<thead>
<tr>
<th>MIPS category</th>
<th>Quality</th>
<th>Cost</th>
<th>EHR use</th>
<th>Practice improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 weight</td>
<td>50%</td>
<td>10%</td>
<td>25%</td>
<td>15%</td>
</tr>
</tbody>
</table>

- Calculated by CMS based on claims; no reporting required
- Measures include:
  - Total per capita costs (Parts A and B);
  - Medicare spending per beneficiary; and
  - 41 condition and treatment episode-based measures
- Each measure must have min 20 patient sample to be counted, then all countable measures are averaged
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<td>15%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Possible points</th>
<th># of obj’s</th>
<th>Are the obj’s mandatory?</th>
<th>Measure Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Score</td>
<td>50</td>
<td>6</td>
<td>All-or-nothing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes; failing to report any base obj will automatically result in a total ACI score of 0</td>
<td></td>
</tr>
<tr>
<td>Performance Score</td>
<td>50*</td>
<td>8</td>
<td>Up to 10 points based on performance relative to benchmark</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No; you can report as many or as little obj’s as are applicable</td>
<td></td>
</tr>
</tbody>
</table>

*Plus an available bonus point for public health registry reporting
MIPS & APMs Proposed Rule

**MIPS: Clinical practice improvement activities**

<table>
<thead>
<tr>
<th>MIPS category</th>
<th>Quality</th>
<th>Cost</th>
<th>EHR use</th>
<th>Practice improvement</th>
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<tr>
<td>Year 1 weight</td>
<td>50%</td>
<td>10%</td>
<td>25%</td>
<td>15%</td>
</tr>
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</table>

- 90-day performance period
- Patient-centered medical homes automatically get full CPIA credit
- APM participants receive half CPIA credit and report 2-3 CPIAs
- Other practices must report 3-6 CPIAs to achieve full credit
- Some CPIAs are worth more than others
- Examples of CPIAs include:
  - 24/7 access to clinicians for urgent/emergency care
  - Timely communication of test results
  - Participation in an AHRQ patient-safety organization
MIPS & APMs Proposed Rule

APMs Takeaways

• Sets extremely narrow criteria for “nominal risk”:
  • Total risk is at least 4% of APM spending target
  • Marginal risk (aka sharing rate) is at least 30%
  • Minimum loss rate must not exceed 4%

• Specifies APMs qualifying for incentives as “advanced APMs”

• Invents new APM category called “MIPS APMs” for which requirements, methodologies and MIPS performance category weighting all differ by model

• Which leaves a grand total of 6 advanced APMs for 2017…
MIPS & APMs Proposed Rule
How will MIPS and APMs interact?

Step 1:
Are you participating in a model that is designated as an advanced APM or a MIPS APM?

Advanced APMs
- MSSP Tracks 2 & 3
- Next Gen ACOs
- Comp ESRD Care (LDOs)
  * CPC+
  * Oncology Care (2-Sided Risk)

MIPS APMs
- Comp ESRD Care (Non-LDOs)
- MSSP Track 1
- Oncology Care (1-Sided Risk)

Step 2:
Does the advanced APM in which you participate meet either qualifying APM threshold?

Meets threshold to become fully qualified APM
Meets threshold to become partially qualified APM
Fails to meet either threshold

Choose

NO; Exempt from participating in MIPS
YES; Participate in MIPS and receive favorable scoring

Step 3:
Will your practice participate in MIPS based on its APM status?

*These models haven’t yet started
## Proposed Timeline for 2019 Payment Year

<table>
<thead>
<tr>
<th>Year</th>
<th>MIPS</th>
<th>APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>1st performance year for MIPS</td>
<td>Likely last performance year for PQRS, VBPM &amp; MU; final MIPS/APM rule expected in fall</td>
</tr>
<tr>
<td>2017</td>
<td>PQRS, VBPM, &amp; MU payment penalties/adjustments sunset Dec. 31</td>
<td>APM qualifying participation status determined for 2019 payments</td>
</tr>
<tr>
<td>2018</td>
<td>1st MIPS payment adjustment year ( +/- 4%)</td>
<td>Payments used to determine 5% incentive bonus in 2019</td>
</tr>
<tr>
<td>2019</td>
<td>First 5% incentive $ distributed to qualifying APM participants</td>
<td></td>
</tr>
</tbody>
</table>
Looking Ahead...
MIPS & APMs Proposed Rule

Next steps for MGMA

• Participate in ongoing meetings with Administration, Congress, and other stakeholders.

• Represent physician practice voice on industry coalitions.

• Track final rule, expected this fall.

• Educate MGMA members on latest updates and continue to develop educational resources.
MIPS & APMs Proposed Rule
MGMA MIPS Recommendations

✓ **Address timing concerns.** Establish a realistic start date, reduce the reporting period, shrink the two-year lag between performance & payment years, and provide more relevant, frequent feedback to practices.

✓ **Reduce the reporting burden.** Simplify/streamline scoring methodologies across categories, reduce the overall number of measures, and award credit for multiple categories.

✓ **Set realistic standards.** Make reporting thresholds & benchmarks that are achievable, based on current data, statistically accurate, and within the practice’s control (e.g. not reliant on 3rd party action).
“Some of the things on the table… include alternative start dates, looking at whether shorter periods could be used, and finding other ways for physicians to get experience with the program before the impact of it really hits them.”

– Congressional testimony from Acting CMS Administrator Andy Slavitt

July 13, 2016
MIPS & APMs Proposed Rule

What physician practices can do now

- Remember this rule is PROPOSED
- Expect MACRA to proceed despite election year politics
- Assess your practice’s performance under current programs
- Consider which path(s) are best suited for your practice
- Evaluate EHR and other vendor readiness and costs
- Explore clinical practice improvement opportunities
- Engage in ongoing learning about MACRA
  - Subscribe to the Washington Connection
  - Visit mgma.org/MACRA for breaking news and educational resources
  - Join our new MIPS/APMs egroup; watch our on-demand webinar
MIPS & APMs Proposed Rule

**MGMA’s recommendations for APMs**

- Significantly expand what constitutes “nominal risk”
  - Include investment, foregone shared savings & care coordination costs
  - Calculate nominal risk based on professional service revenues, as opposed to total APM expenditures

- Drastically broaden the scope and number of qualified APMs
  - Look to the private sector & physician-focused payment models
  - “MIPS APMs” should be counted as fully qualified APMs
  - Institute a transparent, predictable process for reviewing future APM proposals from stakeholders

- Award more MIPS credit for APMs who fell just short of participation thresholds
  - As proposed, practices would get only 7.5% credit towards MIPS score
  - Lots of effort for min credit, esp. when practices won’t know in advance
And then there’s…
<table>
<thead>
<tr>
<th>Hillary Clinton</th>
<th>Donald Trump</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build on/modify existing ACA by increasing exchange tax credits, creating a public option, etc.; possibly expand Medicare; support continued shift to value-based payment models</td>
<td>Repeal ACA; replace with private insurance market that operates across state lines; provide form of tax relief for insurance; remove individual mandate</td>
</tr>
</tbody>
</table>
Political Outlook:
Spotlight on Healthcare
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
# How are payment adjustments applied?

**Current Federal Quality Reporting Programs**

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<thead>
<tr>
<th>PQRS</th>
<th>VBPM</th>
<th>MU</th>
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<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>
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</table>

*MGMA resource:*

How Medicare penalties apply to providers who switch practices