Washington Update

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Agenda

• SGR repealed: what’s next
• Federal quality reporting programs
• ACA implementation
• ICD-10 implementation
SGR

Repealed.
Overview of the SGR repeal bill

• The Medicare Access and CHIP Reauthorization Act (MACRA)
  – Bill text and section-by-section summary. MGMA webinar Apr. 28!

• Bipartisan, bicameral legislation
  – MACRA passed with large majorities in the House of Representatives (392-37) and the Senate (92-8)
  – Supported by physician and hospital organizations - including MGMA

• Prevented 21.2% SGR cut and eliminates threat of future SGR cuts by repealing the payment formula

• 5-year period of stability with positive updates

• Consolidates Medicare quality reporting programs and incentivizes the use of alternative payment models (APMs)
Period of Stable Updates: 2015 - 2025

- Physicians will receive an annual update of 0.5% in each of the years 2015 through 2019
  - The first 0.5% update begins July 1, 2015 and the second 0.5% update begins January 1, 2016
- 2020 through 2025: the annual update will be 0%.
  - Opportunity to receive payment adjustments through MIPS or a financial incentive for participation in an APM
MIPS

- MACRA consolidates federal quality reporting programs into the Merit-Based Incentive Payment System (MIPS)
- Existing Medicare quality reporting programs sunset in 2018 and MIPS begins in 2019
- Four MIPS performance categories:
  - Quality
  - Resource use
  - EHR meaningful use
  - Clinical Practice Improvement Activities
MIPS

- MIPS score for a given year is compared to a previously-established performance threshold
- Composite scores equal to or above the threshold → neutral or positive updates
- Composite scores below the threshold → penalties

<table>
<thead>
<tr>
<th>MIPS Year</th>
<th>Max. bonus or penalty</th>
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<tbody>
<tr>
<td>2019</td>
<td>4%</td>
</tr>
<tr>
<td>2020</td>
<td>5%</td>
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<tr>
<td>2021</td>
<td>7%</td>
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<tr>
<td>2022 and beyond</td>
<td>9%</td>
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MACRA: Alternative Payment Models

• Providers in APMs are excluded from MIPS
• Two APM tracks
  – Medicare Payment Threshold
  – Combination All-Payer and Medicare Payment Threshold
• Examples of APMs
  – Accountable Care Organization (ACO)
  – Patient Centered Medical Home
• Annual lump sum 5% bonus available to APM participants 2019 through 2024
Regulatory work ahead

- Law is only a framework and MACRA is a starting point
- Federal agencies have substantial discretion with rulemaking
  - The devil is in the details
  - “The Secretary shall…”
- Many key details have to be developed through rulemaking
- Regulations provide a significant opportunity to influence the development and implementation of MACRA
- MGMA is highly engaged in working with government agencies to help shape regulations
Federal Quality Reporting Programs
Current Medicare reporting programs

- MACRA does not change current Medicare quality reporting programs until 2019
- Three Medicare quality reporting programs with different criteria, timelines, and penalties:
  - EHR (Meaningful Use) Incentive Program
  - PQRS
  - Value-Based Payment Modifier
- MGMA’s long-standing position: CMS must harmonize and simplify the burdensome quality reporting programs
- The three key programs sunset at the end of 2018
*EPs who were unsuccessful in MU and eRx will receive a 2% penalty in 2015
“Meaningful Use” of Electronic Health Records Program
Meaningful Use: What you need to know in 2015

• Physicians must attest to meaningful use or receive a hardship exception every year to avoid penalties

• In 2015, physicians may be in either Stage 1 or Stage 2
  – Stage 1: 18 total objectives
  – Stage 2: 20 total objectives, including challenging patient engagement measures

• CMS recently released the proposed Stage 3 rule
  – Stage 3 would be mandatory for all EPs beginning in 2018

To learn more:

• Meaningful Use: What MGMA Members Are Asking
• MGMA summary of proposed Stage 3 rule
• MGMA overview of proposed flexibility rule
• CMS Stage 1 vs. Stage 2 comparison table
How to avoid 2016 Meaningful Use penalty

• 2016 meaningful use penalty: -2.0%
• Three ways to avoid the penalty:
  1. Successfully met meaningful use criteria in 2014 and attested by March 20, 2015
  2. New meaningful user in 2015: demonstrate MU for 90 consecutive days and attest by Oct. 1*
     • *Proposed flexibility rule: would change attestation deadline to Feb. 29, 2016 for new meaningful users
  3. Apply for a hardship exception by July 1
     • Instructions for submitting a hardship exception application
     • Application for individual eligible professionals (EPs)
     • Application for multiple EPs – if multiple providers from the same group qualify for the same hardship exception
Proposed changes to Meaningful Use

• MGMA has persistently advocated for added flexibility in meaningful use, including shortened reporting periods
• On Apr. 10, CMS issued a proposed rule that would:
  – Shorten the 2015 reporting period from 1 year to 90 days
  – Reduce thresholds for Stage 2 patient engagement measures:
    • View, download, and transmit: from 5% of patients to 1 patient
    • Secure messaging: from 5% of patients to capability
  – Remove 10 objectives and 2 measures as redundant, duplicative, or “topped out”
  – Require all EPs to move to a modified Stage 2 in 2016
• Learn more with MGMA’s overview of proposed changes
• MGMA will submit comments; expect a final rule in summer
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:
    • In general, 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 PQR 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 PQR 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>
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<tbody>
<tr>
<td>2013</td>
<td>2015</td>
<td>groups w/ 100+ EPs</td>
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<tr>
<td>2014</td>
<td>2016</td>
<td>groups w/ 10+ EPs</td>
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<tr>
<td>2015</td>
<td>2017</td>
<td>all physicians</td>
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- 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
- Upward, neutral or downward adjustment based on quality tiering -4% is the maximum downward adjustment for 2017

Groups of physicians with 10+ EPs
- Upward, neutral or downward adjustment based on quality tiering

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

### Groups with 10+ EPs

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<thead>
<tr>
<th></th>
<th>Low quality</th>
<th>Average quality</th>
<th>High quality</th>
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<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>
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### Groups with 2-9 EPs and solo practitioners

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<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>0%</td>
<td>0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High cost</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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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 group practice reporting option (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

• CMS just released 2014 mid-year QRURs
• Access reports at CMS Enterprise Portal (using IACS log-in)
• MGMA’s QRUR resource webpage
Affordable Care Act Implementation
Supreme Court ACA challenge

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

EFT and ERA operating rules in effect

- You can opt out of virtual credit card payments (unless contracted) and 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

<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>
</tr>
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- CMS plans to release 2014 data later in 2015. Physician review/dispute period began April 6 and continues for 45 days.
- MGMA resource: Open Payments: what you need to know
ICD-10 Transition
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

- 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
MGMA ICD-10 Resources

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

ICD-10 Preparation Guide Part II

More resources to prepare your physicians and staff, and to help work with your vendors to successfully implement the new code set.
Questions?
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)

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

CPT 99490 $42.91

At least 20 minutes over a calendar month

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

Meet CCM criteria, such as establishing a comprehensive care plan
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>
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<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>
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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
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](#)