2018 Washington Update

Mollie Gelburd, JD
Associate Director, Government Affairs

MGMA Government Affairs
Agenda

• Medicare physician payment reform: MIPS & APMs
• 2018 Medicare payment changes
• Trending topics
• MGMA Advocacy and Current Political Environment
• Q&A
Medicare Physician Payment Reform

*MIPS & APMs in 2018*
MIPS Timeline for 2017 Performance Period

- **Apr. 3, 2018**: Last day for all other data reporting
- **Apr. 1, 2018**: CMS provides 2017 performance feedback
- **Dec. 31, 2018**: CMS begins applying payment adjustments to each claim

©2018 MGMA. All rights reserved.
## MIPS Policies: 2017 versus 2018

<table>
<thead>
<tr>
<th>Policy</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penalty or bonus</td>
<td>+/- 4%</td>
<td>+/- 5%</td>
</tr>
<tr>
<td>Reporting period</td>
<td>Any 90 days</td>
<td>Quality and cost: full calendar year ACI and IA: any 90 days</td>
</tr>
<tr>
<td>Category weights</td>
<td>Quality: 60%</td>
<td>Quality: 50%</td>
</tr>
<tr>
<td></td>
<td>ACI: 25%</td>
<td>ACI: 25%</td>
</tr>
<tr>
<td></td>
<td>IA: 15%</td>
<td>IA: 15%</td>
</tr>
<tr>
<td></td>
<td>Cost: 0%</td>
<td>Cost: 10%</td>
</tr>
<tr>
<td>Small practice bonus</td>
<td>None</td>
<td>5 points</td>
</tr>
<tr>
<td>Complex patient bonus</td>
<td>None</td>
<td>Up to 5 points</td>
</tr>
<tr>
<td>Low volume threshold</td>
<td>$30,000 Medicare charges or 100 patients</td>
<td>$90,000 Medicare charges or 200 patients</td>
</tr>
<tr>
<td>CEHRT edition</td>
<td>2014 or 2015</td>
<td>2014 or 2015</td>
</tr>
</tbody>
</table>
Less than $90k in Medicare Part B allowed charges

OR

Less than 200 unique Part B patients

During either of the year-long determination periods
- Sept. 1, 2016 - Aug. 31, 2017
- Sept. 1, 2017 - Aug. 31, 2018
(includes a 30-day claims run-out)

About 35% of Medicare clinicians will fall below the low volume threshold in 2018 and be excluded from MIPS.

JUST UPDATED! MIPS 2018 eligibility info. Check qpp.cms.gov today

©2018 MGMA. All rights reserved.
MIPS Group Reporting

Each eligible clinician participating in MIPS via a group will receive the same payment adjustment based on the group’s performance.

Select 1 reporting mechanism per MIPS performance category.
- CMS Web Interface (only available to groups with 25 or more eligible clinicians)
- Qualified Clinical Data Registry (QCDR)
- Qualified Registry
- Electronic Health Record (EHR)
- Administrative Claims
- CAHPS for MIPS Survey (only available to groups with 2 or more eligible clinicians)
- Attestation

Not every clinician needs to report data for every quality measure so long as data completeness requirements are met.

Only 1 clinician needs to attest to completing an improvement activity.
2018 MIPS Payment Adjustments

Final MIPS score in 2018: 0-100 points

Payment adjustment in 2020

- ≤ 3 points = -5% reduction
- 15 points = break even point
- 70 points = exceptional bonus

ECs and groups assigned final score of 0-100 points based on performance.
Final score compared to performance thresholds set by CMS each year.
Scores above threshold result in a bonus; scores below threshold get a penalty.
CMS: 2020 MIPS Payment Adjustment Outlook

- 97% avoid a penalty
- 74% earn an exceptional bonus
- $618m total bonus payments
- $118 mil (expected)
- $500 mil
MIPS Payment Adjustments, Bonuses and Hardships

**PAYMENT ADJUSTMENTS**

*How can I achieve 15 points?*

- Report all required Improvement Activities
- Meet ACI base score and submit 1 Quality measure that meets data completeness
- Meet ACI base score, by reporting the 4 or 5 base measures, and submit one medium-weighted IA
- Submit 6 Quality measures that meet data completeness criteria

**BONUSES**

**SMALL PRACTICE BONUS: 5 POINTS**

**COMPLEX PATIENT BONUS: UP TO 5 POINTS**

Must submit data for at least *one* MIPS category to be eligible.

Added to final MIPS score.

**HARDSHIPS**

New automatic hardship granted to those in areas impacted by natural disasters.

- CMS uses practice location from PECOS & FEMA-designated disaster areas.

ECs/groups have option to submit, receive score, & receive a payment adjustment.
APMs: MACRA’s second payment track

What is an APM?

An APM is a payment arrangement between a provider organization and CMS (or another payer) structured around quality and cost metrics. The organization, or APM Entity, contracts with CMS and aims to achieve Medicare cost savings relative to certain benchmarks. To the extent that the APM Entity saves CMS money, APM participants get to share those savings.

Different models offer varying levels of upside and downside financial risk.

What is an Advanced APM?

An advanced APM is one that also takes on a sufficient amount of risk, putting the APM Entity on the hook for returning money to CMS if they exceed cost benchmarks.

Providers who sufficiently participate in an advanced APM get a 5% lump sum bonus (paid 2019-2024), calculated from their Medicare Part B claims in a prior year, and are exempt from any MIPS reporting requirements and $ adjustments.
### 2018 Advanced APMs

<table>
<thead>
<tr>
<th>MSSP Tracks 2 &amp; 3 and the new Track 1+ *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Next Generation ACOs</td>
</tr>
<tr>
<td>Comprehensive Primary Care Plus</td>
</tr>
<tr>
<td>Comprehensive ESRD Care (2-sided risk)</td>
</tr>
<tr>
<td>Oncology Care Model (2-sided risk)</td>
</tr>
<tr>
<td>Comp Care for Joint Replacement (CEHRT track) *</td>
</tr>
</tbody>
</table>

* = New opportunity in 2018

CMS estimates 185,000–250,000 clinicians will participate in Advanced APMs in 2018

NEW APM – BUNDLED PAYMENTS FOR CARE IMPROVEMENT (BPCI) ADVANCED

Application deadline was March 12, 2018 and the first cohort of participants will start participation in the model on October 1, 2018. The model performance period will run through December 31, 2023 and a second application opportunity will open in January 2020.

CMS BPCI Advanced Website
Should the government mandate participation in Medicare APMs?

Feb. 27, 2018 poll
1,176 responses
Physician Practice Action Steps

**Assess** performance under past reporting programs

**Evaluate** vendor readiness & costs (ask about 2015 CEHRT!)

**Protect** your practice against a MIPS penalty

**Determine** your 2018 MIPS goal; establish a reporting strategy

**Comply** with deadlines (hardship exception, CAHPS for MIPS, MSSP, etc.)

**Analyze** data at year-end; hone final reporting strategy

**Leverage** MGMA resources to educate yourself, your physicians and staff
2018 Medicare Physician Payment Changes
### Key Policies in PFS

<table>
<thead>
<tr>
<th>Policy</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-excepted, off-campus provider-based hospital outpatient department payment rates equivalent to 40% of OPPS payment rate.</td>
<td></td>
</tr>
<tr>
<td>Mandatory consultation of appropriate use criteria for advanced imaging services delayed until 2020.</td>
<td></td>
</tr>
<tr>
<td>MACRA patient relationship HCPCS modifiers may be voluntarily reported beginning Jan. 1.</td>
<td></td>
</tr>
<tr>
<td>Medicare Diabetes Prevention Program starts April 1.</td>
<td></td>
</tr>
</tbody>
</table>
Digital Health Services in 2018

**Telehealth**

Eliminated required use of GT modifier on telehealth claims; distant site providers will continue to use Place of Service (POS) code 02.

Added 7 new codes to list of covered codes.

Statutory restrictions on geographic location, originating site, and eligible provider type still in place for most services and groups.

**Remote Patient Monitoring**

CMS finalized separate payment for RPM services by unbundling CPT code 99091 – collecting and interpreting physiologic data.

RPM services are not subject to the same strict requirements as telehealth, but must meet CPT criteria to be reimbursable.

Ten action steps for incorporating data from patient wearables into an EHR

*Telehealth: Adoption & Best Practices*
MGMA Resources

**Washington Connection**
Weekly e-newsletter with breaking updates and everything you need to know from our nation’s capital

**MACRA/QPP Resource Center**
Your one-stop shop for new resources & information
- MACRA FAQs

**Dedicated MIPS/APMs e-group**
Get your questions answered and engage in a dialogue with your MGMA peers about all things MACRA
Other Trending Topics
Prior authorization requirements continue to rise

IN THE PAST YEAR, PAYER PRIOR AUTHORIZATION REQUIREMENTS HAVE:

- 86% INCREASED
- 11% STAYED THE SAME
- 3% DECREASED

MAY 16, 2017 POLL
1041 APPLICABLE RESPONSES OUT OF 1095 TOTAL RESPONSES.
FOR MORE INFORMATION, VISIT MGMA.ORG/POLLS.
January 2018 Provider/Plan Joint Statement on Prior Authorization

Reduce the number of clinicians subject to PA requirements based on their performance, adherence to evidence-based medical practices, or participation in value-based agreements.

Regularly review the services and medications that require PA and eliminate requirements for therapies that no longer warrant them.

Improve channels of communications between plans, providers, and patients to minimize care delays and ensure clarity on PA requirements, rationale, and changes.

Protect continuity of care for patients who are on an ongoing, active treatment or a stable treatment regimen when changes in coverage, plans or PA requirements.

Accelerate industry adoption of national electronic standards for PA and improve transparency of formulary information and coverage restrictions at the point-of-care.
New Medicare Cards

SOCIAL SECURITY NUMBER REMOVAL INITIATIVE (SSNRI)

Starting April 2018, CMS will:

• Assign 150 million Medicare Beneficiary Identifiers (MBIs) in the initial enumeration (60 million active/90 million decease/archived) and each new beneficiary

• Generate a new unique MBI for Medicare beneficiaries whose identity has been compromised

• Medicare claims can use old HICN until Jan. 2020
New Medicare Cards

Key Practice Checklist Items

- Conduct Patient Outreach
  - Educate your patients (posters, flyers)
  - Remind patients to protect their new Medicare number and only share it with trusted providers

- Get Ready to Use the New MBI Format
  - Talk/test with your PMS vendor and ensure systems and workflow can accommodate HICNs and MBIs
  - Ask billers about their MBI preparations
  - Ensure access to the MAC portal to obtain a patient’s MBI starting in June 2018

- Access the MGMA New Medicare Card Member Resource
MGMA Advocacy and Current Political Environment
Technical Amendments to MACRA make several changes that MGMA has been strongly advocating for, including:

- **Excludes Medicare Part B drug costs from MIPS payment adjustments and from the low-volume threshold determination.**
- **Eliminates improvement scoring for the cost category for the third, fourth and fifth years of MIPS.**
- **Allows CMS to reweight the cost category to 10 percent (or more) the third, fourth, and fifth years of MIPS.**
- **Allows CMS flexibility in setting the performance threshold for years three through five.**
- **Improves Physician Focused Payment Model Technical Advisory Committee (PTAC) feedback process.**
Bipartisan Budget Act of 2018
Passed into law on February 9, 2018

Provisions in the Act that are important to medical groups:

- Eliminate the unelected Medicare cost-cutting board known as the IPAB.
- Permanently repeal the Medicare therapy payment cap.
- Expand coverage for telehealth services.
- Extend the work Geographic Practice Cost Index (GPCI) 1.0 floor for two years through 2019.
- Extend Children's Health Insurance Program funding for an additional four years through fiscal year 2027.
Bipartisan Budget Act of 2018
How did Congress pay for those wins?

MGMA advocacy defeated flawed misvalued code payment cut included in House bill:

Disappointing offset in an otherwise favorable bill:

Legislative alert: Tell Congress not to cut Medicare physician payments

Today, the U.S. House of Representatives is expected to vote on a short-term spending bill that would fund the federal government through March 23. The bill contains a number of healthcare provisions, but to offset the cost of these provisions, the legislation would extend Medicare’s misvalued code policy through 2019. Medicare’s misvalued code policy is largely to blame for reductions to the Medicare conversion factor in 2016-2018. Extending it would lead to more across-the-board cuts to Medicare payments. Urge your members of Congress not to cut Medicare payments to physician practices.
MGMA Advocacy at Work for Practices

MGMA continuously voices medical group practice opposition to Medicare reimbursement cuts. For 2018, we are focusing on:

- Modernizing the Stark law and preserving the in-office ancillary services exception
- Stopping the sequester cuts to Medicare
- Making MIPS simpler and more predictable
- Regulatory relief

Visit our Contact Congress Portal and lend your voice.
MGMA Advocacy Priority: Regulatory Relief

MGMA to HHS: reduce excessive federal mandates and one-size-fits all regulations; support high-quality, cost-effective care delivery.

- Patients over Paperwork initiative with CMS
- Cut the Red Tape summit with HHS
- President Trump signed “2-for-1” regulations Executive Order in Jan. 2017

Medicare Red Tape Relief Project with House W&M committee

Visit MGMA.com/regrelief to learn more.
Questions?

Mollie Gelburd, JD
Associate Director, Government Affairs

MGMA Government Affairs
Quality

50 Points / 50% OF FINAL SCORE | 12 MONTH REPORTING PERIOD

2018 IN BRIEF

- Report 6 measures on 60% of applicable patient encounters, except CAHPS and CMS Web Interface
  - Measures that do not meet data completeness criteria earn 1 point
- No additional cross-cutting measure requirement
- 12-month reporting period
- Improvement bonus up to 10% of quality score available

MAXIMIZE YOUR SCORE

- Benchmarks for same measure vary by reporting mechanism
- Limited to one reporting mechanism within the category
- Bonus points for all reported measures even if the measure not counted (up to 10% cap)
- Data completeness thresholds are based on the proportion of applicable patients, not the number of clinicians who report data

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 21</td>
<td>Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin</td>
</tr>
<tr>
<td>Measure 23</td>
<td>VTE Prophylaxis (When Indicated in ALL Patients)</td>
</tr>
<tr>
<td>Measure 52</td>
<td>COPD: Inhaled Bronchodilator Therapy</td>
</tr>
<tr>
<td>Measure 224</td>
<td>Melanoma: Overutilization of Imaging Studies in Melanoma</td>
</tr>
<tr>
<td>Measure 262</td>
<td>Image Confirmation of Successful Excision of Image-Localized Breast Lesion</td>
</tr>
<tr>
<td>Measure 359</td>
<td>Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for CT Imaging Description</td>
</tr>
</tbody>
</table>
Cost

10 POINTS / 10% OF FINAL SCORE | 12 MONTH REPORTING PERIOD

2018 IN BRIEF

- Two cost measures formerly used in Value Modifier:
  - Total cost of care for attributed beneficiaries
  - Medicare spending per beneficiary
- No reporting requirements – administrative claim data
- Performance compared against a 2018 benchmark
- CMS will use average of both measures
- Measures risk adjusted for demographic factors and clinical conditions
### Future Outlook for Cost Performance Category

#### MIPS in 2018

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
</tr>
<tr>
<td>Cost</td>
<td>10%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
</tbody>
</table>

#### MIPS in 2019 and beyond

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>30%</td>
</tr>
<tr>
<td>Cost</td>
<td>10%, 20%, 30%?*</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
</tbody>
</table>

*Incomplete:

- Episode-based cost measures
- MACRA patient relationship categories
- Improved risk adjustment
- Actionable patient attribution, resource use data

*Bipartisan Budget Act of 2018 Allows CMS to reweight the cost performance category to not less than 10 percent for the third, fourth, and fifth years of MIPS
Improvement Activities

15 POINTS / 15% OF FINAL SCORE | 90 DAY REPORTING PERIOD

2018 IN BRIEF

- No change to:
  - 90-day reporting period
  - Scoring policies,
  - Category weight, or
  - Reporting mechanisms

- Additional activities to choose from

- Report via yes/no attestation in portal by Mar. 31 following performance period

SEVERAL PATHS TO FULL-CREDIT

<table>
<thead>
<tr>
<th>Ex.</th>
<th>Reported Activities</th>
<th>Points Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>H H</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>H M M M</td>
<td>40</td>
</tr>
<tr>
<td>3</td>
<td>M M M M M</td>
<td>40</td>
</tr>
</tbody>
</table>

H  High-weighted activity: 20 points

M  Medium-weighted activity: 10 points
Advancing Care Information (ACI)

25 POINTS / 25% OF FINAL SCORE | 90 DAY REPORTING PERIOD

2018 IN BRIEF

- No change to 90-day reporting period, category weight, 2014 CEHRT permitted
- ECs/groups can still choose from 2018 transitional measures (modified stage 2 MU) or 2018 measures (stage 3 MU)
- New bonus offered for reporting 2018 measures using 2015 CEHRT
- Technical updates to certain measures; requirements for public health registry measure relaxed
- Previous MU measure-specific exclusions implemented
- More providers qualify for ACI re-weighting or hardship due to “special status”

SPECIAL STATUS

- Non-physician practitioners
- Hospital-based ECs
- Ambulatory Surgical Clinic ECs*
- Non-patient facing ECs & groups
- Those facing a significant hardship
  - MU categories
  - Small practices*
  - De-certified EHR*

* New under 2018 QPP rule
ACI To-Do List

**Check who’s exempted from ACI**

CMS also finalized measure-specific exclusions for e-Rxing and Health Information Exchange.

ECs exempted from ACI are included in group score.

Practices with multiple EHR systems or practice sites can still report at the TIN level by adding up measure performance results in the attestation portal.

**Consider implications of group reporting**

**Understand how measures are scored**

Base score = all or nothing (50% of ACI or 12.5 overall MIPS points)

Performance measures = each measure scored out of 10 or 20 points based on performance rate; CMS adds up all points earned for reported measures to calculate performance score (50% of ACI or 12.5 overall MIPS points)

**Look for opportunities for bonus points**

Report IAs using CEHRT (10%)

Report to more than one public health registry (5% for each additional registry)

Report 2018 measures using 2015 CEHRT (10%)

Report by March 31
2018 MIPS Scoring Example

Small Group Practice

ACI
- Report no data: Exempted
- Hardship Exception: 0

COST
- 50% Performance Score: 5 Points
- 10

QUALITY
- 5% Performance Score: 3.75 Points
- 75

IMPROVEMENT ACTIVITIES
- 50% Performance Score: 7.5 Points
- 15
- Complex patient bonus (up to 5 points): 3 points
- Small practice bonus: 5 points

Final MIPS Score: 24.25 points

©2018 MGMA. All rights reserved.
2018 MIPS Scoring Example

MEDIUM GROUP PRACTICE

<table>
<thead>
<tr>
<th>ACI</th>
<th>100% Performance Score</th>
<th>25 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COST</th>
<th>50% Performance Score</th>
<th>5 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QUALITY</th>
<th>75% Performance Score</th>
<th>37.5 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMPROVEMENT ACTIVITIES</th>
<th>100% Performance Score</th>
<th>15 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Complex patient bonus (up to 5 points)

Small practice bonus

Final MIPS Score 85.5 points

©2018 MGMA. All rights reserved.
# 2018 MIPS Scoring Example

**MIPS APM**

<table>
<thead>
<tr>
<th>Component</th>
<th>Weight</th>
<th>Performance Score</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACI</strong></td>
<td>30%</td>
<td>50%</td>
<td>15</td>
</tr>
<tr>
<td><strong>COST</strong></td>
<td>0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>QUALITY</strong></td>
<td>50%</td>
<td>40%</td>
<td>20</td>
</tr>
<tr>
<td><strong>IMPROVEMENT ACTIVITIES</strong></td>
<td>20%</td>
<td>100%</td>
<td>20</td>
</tr>
</tbody>
</table>

**Additional Performance Threshold**

- 0 points
- 15 points
- 70 points

**Final MIPS Score**

55 points
Today’s Security Environment

CHECKLIST TO PROTECT YOUR PRACTICE

1. CONDUCT a complete HIPAA Security Risk Assessment
2. KEEP computer operating systems and antivirus software up-to-date
3. ENCRYPT all files and systems that contain patient information
4. DEPLOY strong user authentication
5. ENSURE that your business associates are protecting your data
6. REQUIRE training for all practice staff
7. INSTRUCT staff not to open emails/attachments/links from unfamiliar senders
8. BACK UP patient data (offsite)
9. RUN periodic system tests
10. CONSIDER cyber insurance
2018 PFS Calculation

Total RVUs from fee schedule

Conversion factor

Adjusted for:

Complexity of service and expenses

Work RYU

Work GPCI

Payment modifier

Adjusted fee schedule payment rate

Geographic factors

Work RYU

FF RYU

PL RYU

Policy adjustments (multiplicative)

Provider type

Non-physician billing independently

Non-participating

Geographic

HPSA bonus

Performance in quality programs

Physician Quality Reporting System

Meaningful use of certified electronic health records

Value-based payment modifier

Payment

(increases)

(decreases)

(decreases)

(increases, decreases, or no change)
Retroactive penalty reductions to PQRS and Value Modifier

PQRS
As a result of MGMA advocacy, CMS will:

- Retroactively reduce CY 2016 PQRS quality reporting requirements to six measures with no domain or cross-cutting measure requirements and
- Make CAHPS for PQRS optional

Estimated to reduce physician penalties by $22 million

Value Modifier
As a result of MGMA advocacy, CMS will:

- Hold all groups who met 2016 PQRS requirements harmless from any VM penalties in 2018
- Halve penalties for those who did not meet PQRS requirements to -2% for groups with 10 or more eligible professionals and to -1% for smaller groups and solo practitioners
- Not publicly report 2016 value modifier data on its Physician Compare web site