Washington Update

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Agenda

- Post-SGR repeal: What's next for Medicare
- Proposed 2016 Medicare physician fee schedule
- Current federal quality reporting programs
- ICD-10 implementation

SGR repeal and replacement

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - MACRA text and section-by-section summary
  - MGMA on-demand webinar
- Bipartisan, bicameral legislation
  - MACRA passed with large majorities in the House of Representatives (392-37) and the Senate (92-8)
  - Supported by MGMA and all physician organizations
- Prevented 21.2% SGR cut and eliminates threat of future SGR cuts by repealing the payment formula

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MACRA

- Stabilizes Medicare physician fee schedule updates
  - Physicians will receive an annual update of 0.5% in each of the years 2015 through 2019
    - The first 0.5% increase took effect on July 1
    - Updated Medicare conversion factor: **$35.9335**
- Consolidates federal quality reporting programs
  - Current penalties under Meaningful Use, PQRS, and VBPM sunset at the end of 2018
  - Starting in 2019, Merit-Based Incentive Payment System (MIPS) is only Medicare quality reporting program in effect
    - MIPS bonuses and penalties based on performance in four categories: quality, resource use, meaningful use of EHR technology, and clinical practice improvement activities

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MACRA

- Creates a pathway for practices to participate in alternative payment models (APMs)
  - Annual lump sum 5% bonus available to APM participants from 2019 through 2024
  - Providers in APMs are exempt from MIPS reporting system
  - Examples of APMs:
    - Accountable care organization (ACO)
    - Patient-centered medical home
  - HHS will work with physicians to develop additional APMs
- Extends therapy caps exception process, 1.0 GPCI work floor, and other Medicare “extender” policies

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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

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Proposed 2016 Medicare Physician Fee Schedule (PFS)

Fast Facts on the Proposed 2016 PFS

- 2016 Medicare PFS proposed rule released July 8
  - **MGMA's comprehensive analysis walks through critical changes impacting medical group practices**
  - CMS fact sheet on payment and quality reporting proposals
  - Proposed Medicare RVU files
- MGMA will submit comments to CMS in early Sept.
- Final rule expected by Nov. 1
- Impacts payments starting Jan. 1, 2016

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Proposed 2016 Medicare PFS

- Key proposals:
  - Setting 2016 Medicare payment rates for physician services, including a 0.5% payment increase as a result of MACRA
    - *Estimated* 2016 Medicare conversion factor: $36.1096
  - Establishing 2016 performance year quality reporting criteria for the PQRS and Value-Based Payment Modifier
  - Increasing the amount of information about physicians and practices on the *Physician Compare* website

Proposed 2016 Medicare PFS

- Key proposals:
  - Outlining proposed RVU and payment changes for services deemed misvalued by CMS
    - Includes 118 codes that account for high expenditure services in Medicare
    - CMS required to make net reductions of 1% of PFS or money is removed from physician pool
  - Clarifying that the physician or NPP who supervises "incident to" services must bill for those services
  - Beginning implementation of MACRA
    - Ex: automatic renewal of Medicare opt-out affidavits

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

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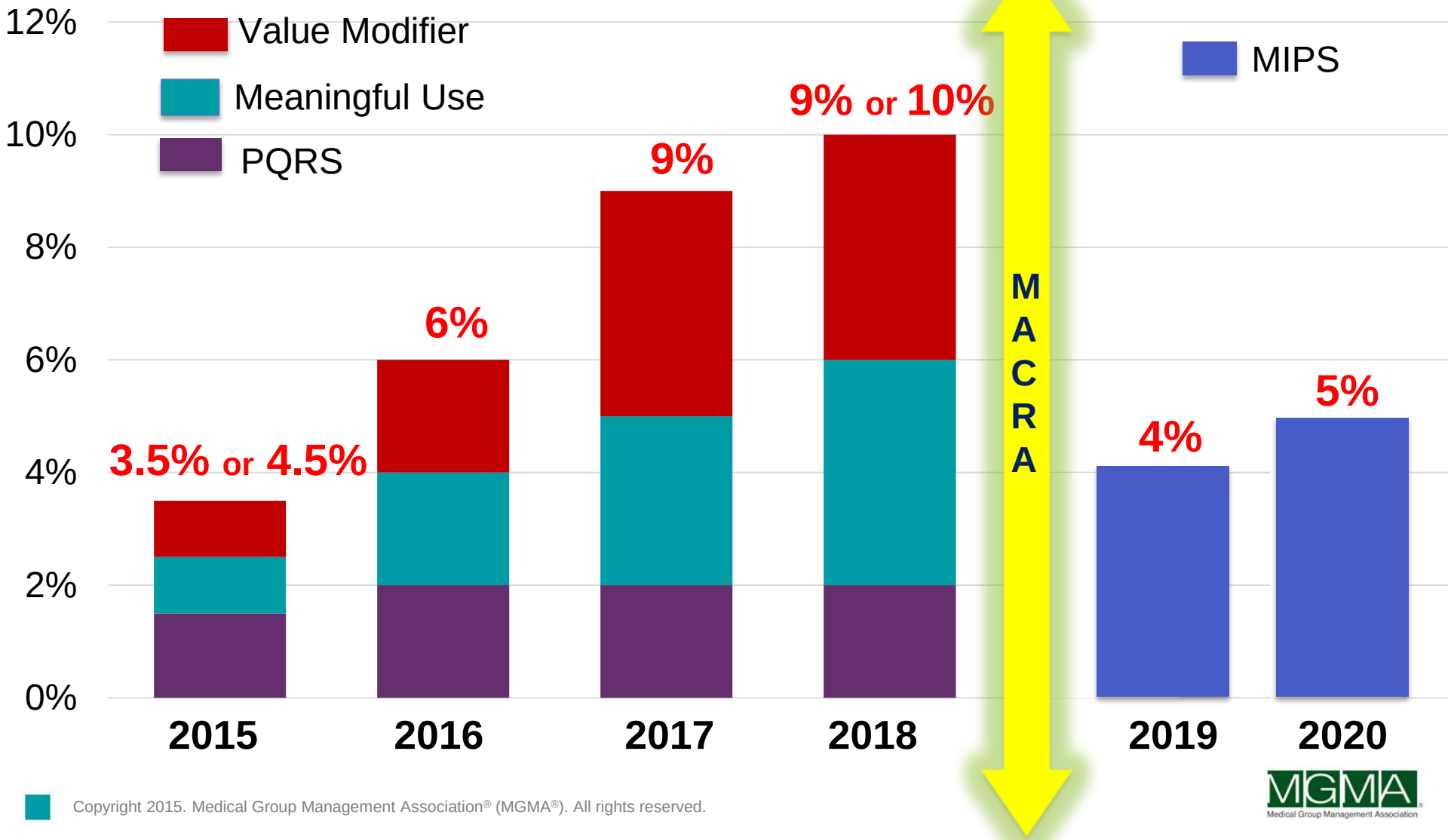
Maximum Medicare payment at risk



Meaningful Use

- 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
- Physicians must attest to meaningful use or receive a hardship exception *every year* to avoid penalties
- In March, CMS released the proposed Stage 3 rule
  - Would be mandatory for all EPs beginning in 2018

Learn more:

- Meaningful Use: What Members Are Asking
- CMS Stage 1 vs. Stage 2 comparison table
- MGMA overview of proposed flexibility rule
- MGMA summary of proposed Stage 3 rule

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Meaningful Use: Changes ahead

- Rep. Ellmers introduced “Flex-IT 2” Act (H.R. 3309) in July
  - Delays Stage 3 rulemaking until 2017, unless at least 75% of EPs and hospitals are successful in Stage 2
  - Institutes 90-day reporting period each year, regardless of stage
  - Expands hardship exceptions
- After pressure from MGMA, other provider orgs, and Congress, CMS issued a flexibility proposed rule on April 10
  - 90 consecutive day reporting period for 2015, all year in 2016
  - View, download, and transmit data reduced from 5% to 1 patient
  - Secure messaging reduced from 5% to having capability
  - Learn more with MGMA’s overview of proposed changes
  - MGMA submitted comments; expect a final rule in Sept.

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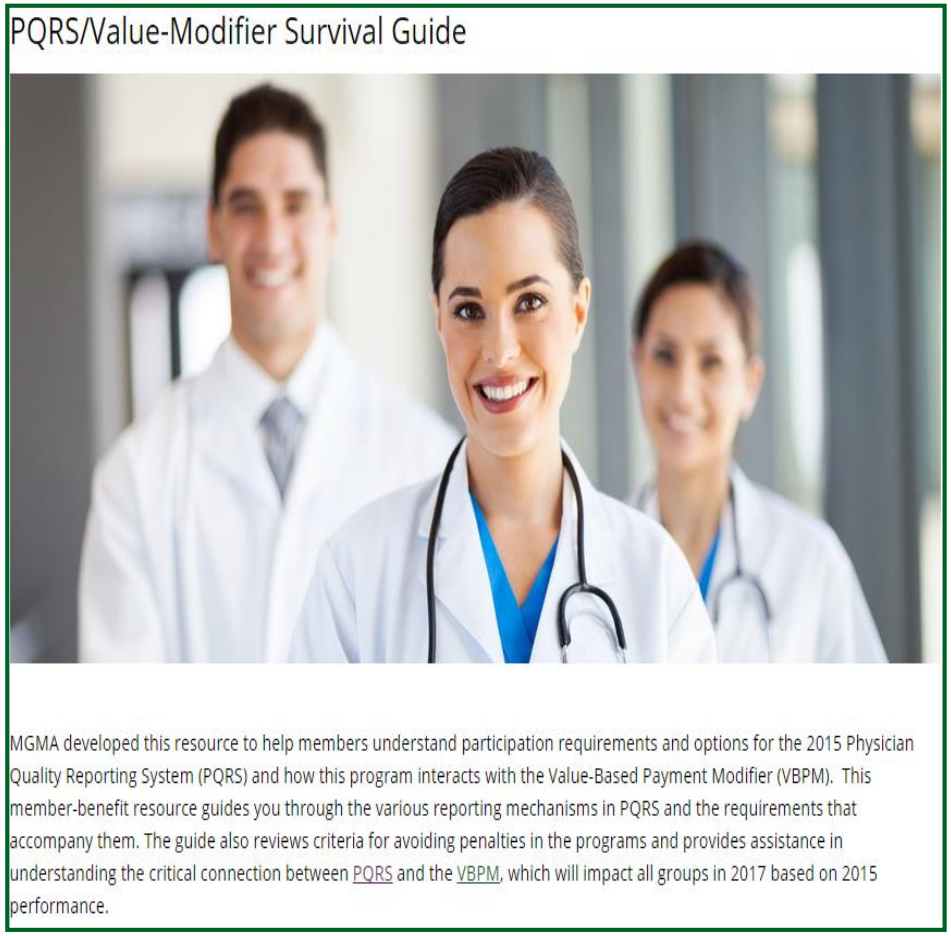
2015 PQRS overview

- EPs and group practices must satisfy 2015 PQRS reporting requirements to avoid the 2017 PQRS penalty
  - 2017 PQRS penalty based on 2015 reporting: **- 2%** of Medicare Part B covered professional services
  - **New! MGMA resource: "How will Medicare penalties apply to providers who switch practices?"**
- In general, EPs and group practices must report 9 quality measures covering 3 NQS domains for 50% of applicable patient encounters
  - New cross-cutting measure requirement if EP sees a Medicare patient in face-to-face encounter and reports via claims or registry
- On July 13, CMS retired IACS accounts and transitioned IACS users to EIDM to access the new PQRS portal

PQRS: Proposed 2016 changes

- Proposed changes:
  - Maintaining reporting requirement for avoiding a 2018 penalty at 9 measures for claims and registry reporting options
  - Requiring group practices with 25 or more EPs to report CAHPS patient satisfaction survey data **IF** they elect the web interface group practice reporting option (GPRO)
  - Expanding qualified clinical data registry (QCDR) reporting option to group practices in GPRO
    - In 2014 and 2015, CMS limited the QCDR reporting option to individual EPs only
  - Retiring, adding, and modifying many PQRS measures and measures groups

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!**

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Value-Based Payment Modifier (VBPM)

- Budget-neutral program that is closely tied with PQRS and differentiates provider payment based on cost and quality of care
- Phased in over three years and impacts all physicians in 2017

Performance year	Modifier year	Impacted providers
2013	2015	Groups w/ 100+ EPs
2014	2016	Groups w/ 10+ EPs
2015	2017	All physicians
2016	2018	Physicians, PAs, NPs, CNSs and CRNAs

- Physicians that don't participate in 2015 PQRS face an automatic VBPM penalty on top of the automatic PQRS penalty
- Potential bonuses & penalties under "quality-tiering"

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VBPM: Proposed 2016 changes

- Proposed changes:
  - Applying VBPM to PAs, NPs, CNSs, CRNAs, as well as all physicians, in 2018 based on 2016 data
  - Maintaining maximum Medicare payment at risk under VBPM at 4%
  - Exempting groups that participate in a Pioneer ACO or Comprehensive Primary Care Initiative model beginning in 2017
  - Exempting groups that participate in Comprehensive ESRD Care Initiative, Oncology Care Model, or Next Generation ACO Model beginning in 2018

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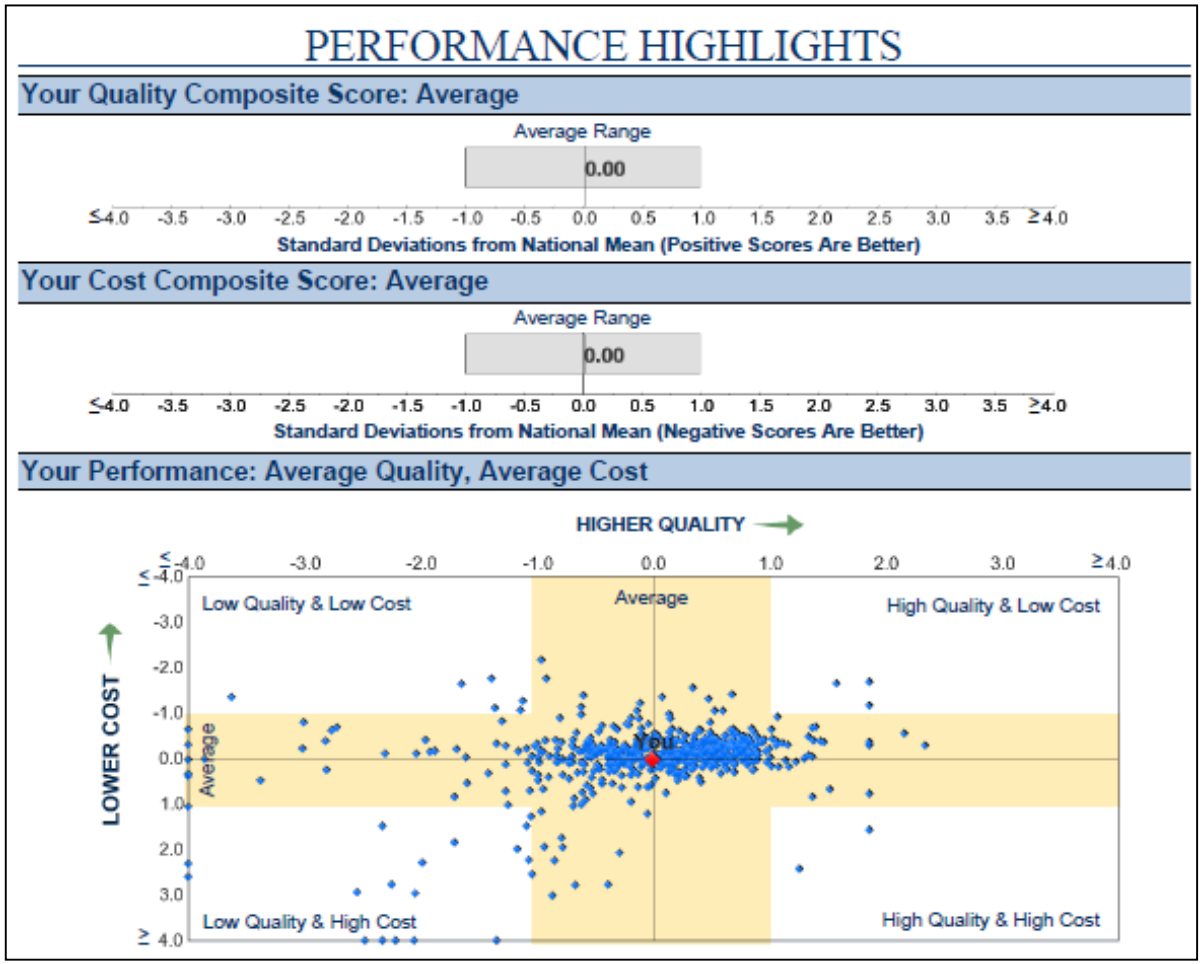
Quality and Resource Use Reports

QRURs include comparative performance data on cost and quality measures and preview outcome under VBPM

- CMS released 2014 mid-year QRURs
- Access reports at CMS Enterprise Portal
- MGMA's QRUR resource webpage



MGMA's Advocacy Principles

- The current maze of measures and reporting processes is overly burdensome and not translating to better patient care
  - MGMA research shows a majority of practices are independently engaged in clinical practice improvement activities
  - Yet most say that the Medicare quality reporting programs are needlessly complex and are not enhancing their practice
- MIPS presents a unique opportunity to work towards harmonizing the quality reporting programs and reducing administrative burdens on practices

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ICD-10 Implementation

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
    - Providers can submit acknowledgement test claims to Medicare at any time through Oct. 1. Learn more here!
- **Medicare back-end flexibility**: Non-specific codes will not be denied by Medicare auditors as long as the codes are from the appropriate "family" through Oct. 1, 2016. Learn more.

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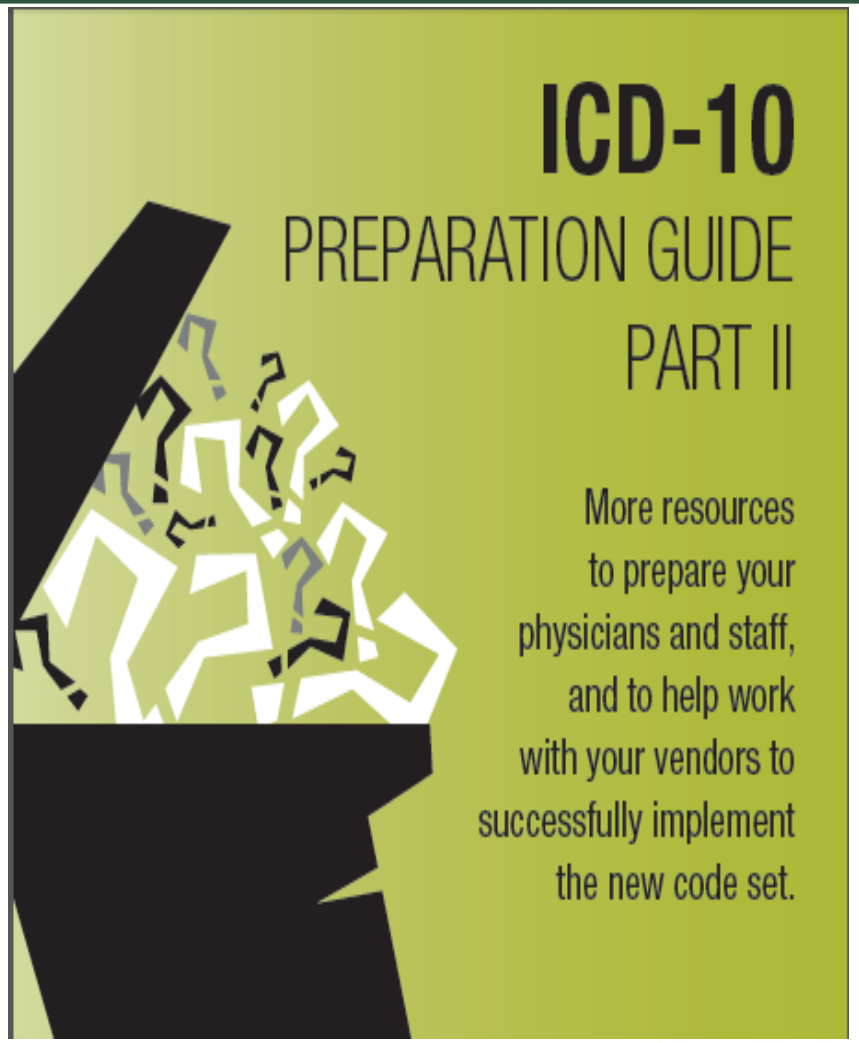
MGMA ICD-10 Resources

On-demand MGMA ICD-10 webinar: Critical steps to prepare your practice as the clock winds down

Access more MGMA ICD-10 resources:

- Comprehensive ICD-10 Preparation Guide
- ICD-10 Preparation Guide Part II
- Cypher ICD-10 Clinical Documentation Software
- Find more tools and tips at MGMA's ICD-10 Resource Center



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Code-FLEX Act (H.R. 3018)

- Reps. Blackburn and Price introduced Code-FLEX Act
  - Allows providers to submit ICD-9 or ICD-10 codes for 6 months to both Medicare *and* private payers
  - Requires HHS Sec. to give Congress a status report
  - Not a delay – practices that are ready can move ahead

Your help is critical to getting H.R. 3018 passed!

- Urge your members of Congress to support this glide path for a smoother transition to ICD-10 by cosponsoring the Code-FLEX Act
- Visit MGMA's Legislative Advocacy Center today!

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Questions?

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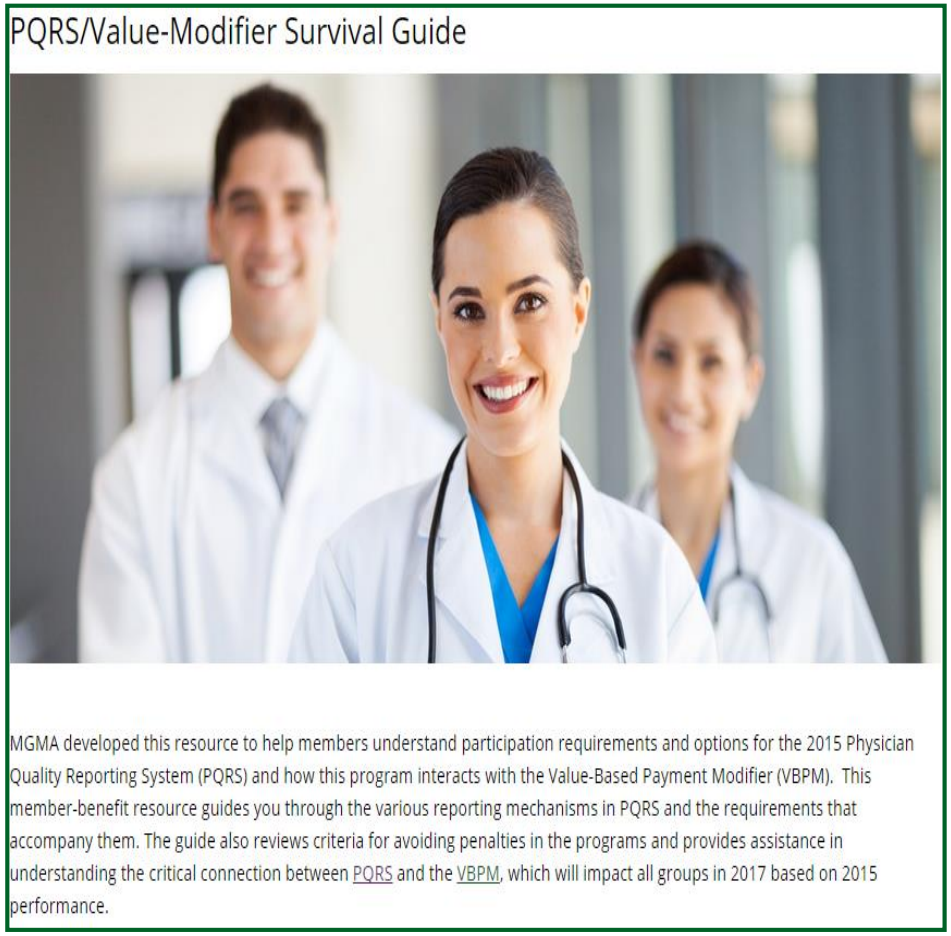
Appendix

PQRS-Value Modifier Survival Guide



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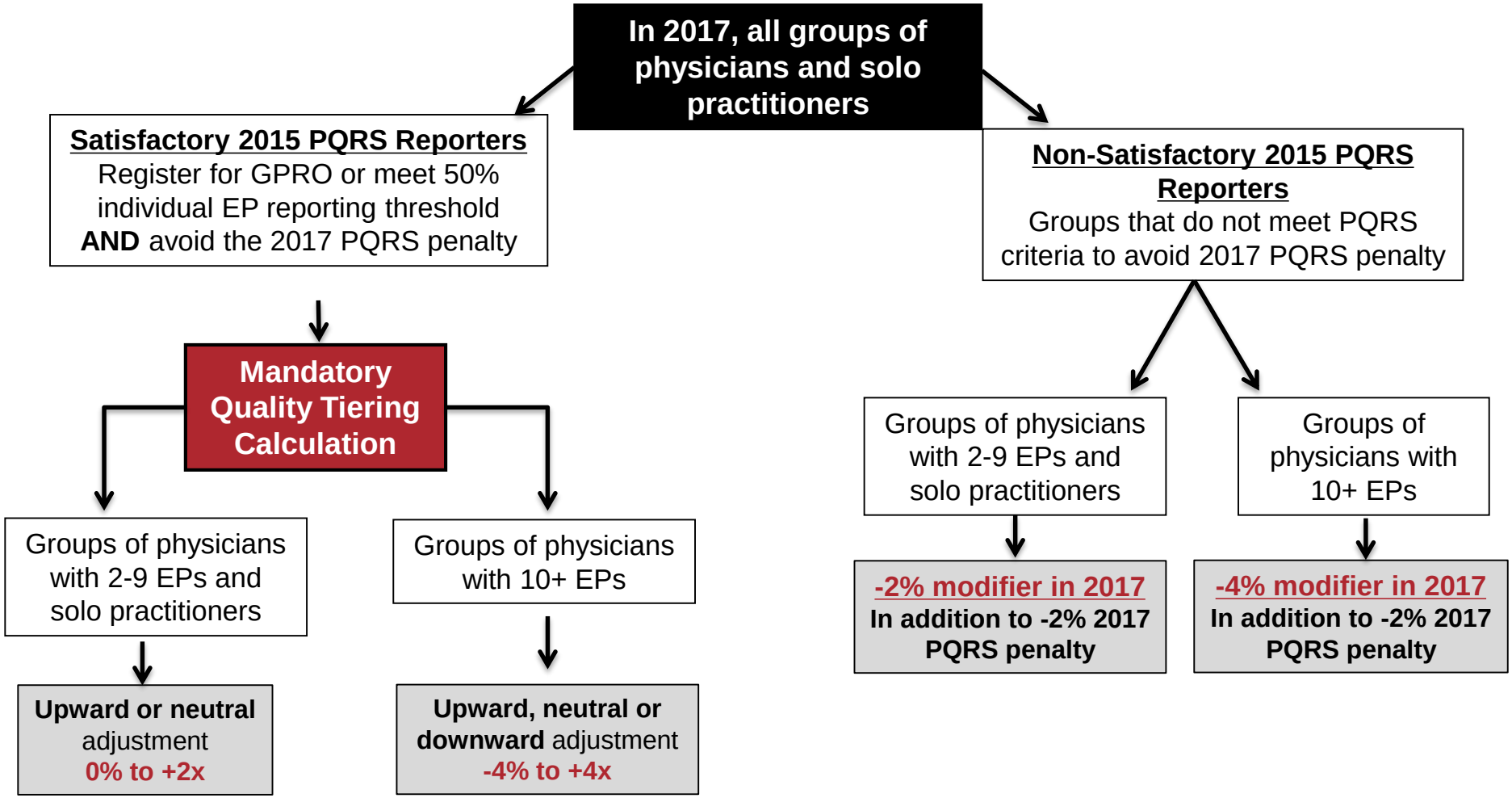
Legislation to Watch

- ICD-10 Legislation
  - H.R. 3018 the Code-FLEX Act
  - H.R. 2247 ICD TEN ACT
  - H.R. 2652 Protecting Patients & Physicians Against Coding Act
  - H.R. 2126 Cutting Costly Codes Act
- Flex-IT 2 Act H.R. 3309
- Medicare Common Access Card H.R. 3220/S.1871
- Various GME legislation

2017 VBPM: How it works



2017 VBPM: Next steps to prepare your practice

1. Participate in PQRS **in 2015**:
   - Register for and satisfactorily participate in 2015 PQRS **group practice reporting option (GPRO)**, or
   - 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.
2. Familiarize yourself with VBPM program requirements
3. Access your 2013 QRUR reports

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2017 VBPM scoring under quality tiering calculation

Groups with 10+ EPs

	Low quality	Average quality	High quality
Low cost	0%	**+2.0x***	**+4.0x***
Average cost	**- 2.0%**	0%	**+2.0x***
High cost	**- 4.0%**	**- 2.0%**	0%

Groups with 2-9 EPs and solo practitioners

	Low quality	Average quality	High quality
Low cost	0%	**+1.0x***	**+2.0x***
Average cost	0%	0%	**+1.0x***
High cost	0%	0%	0%

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%

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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

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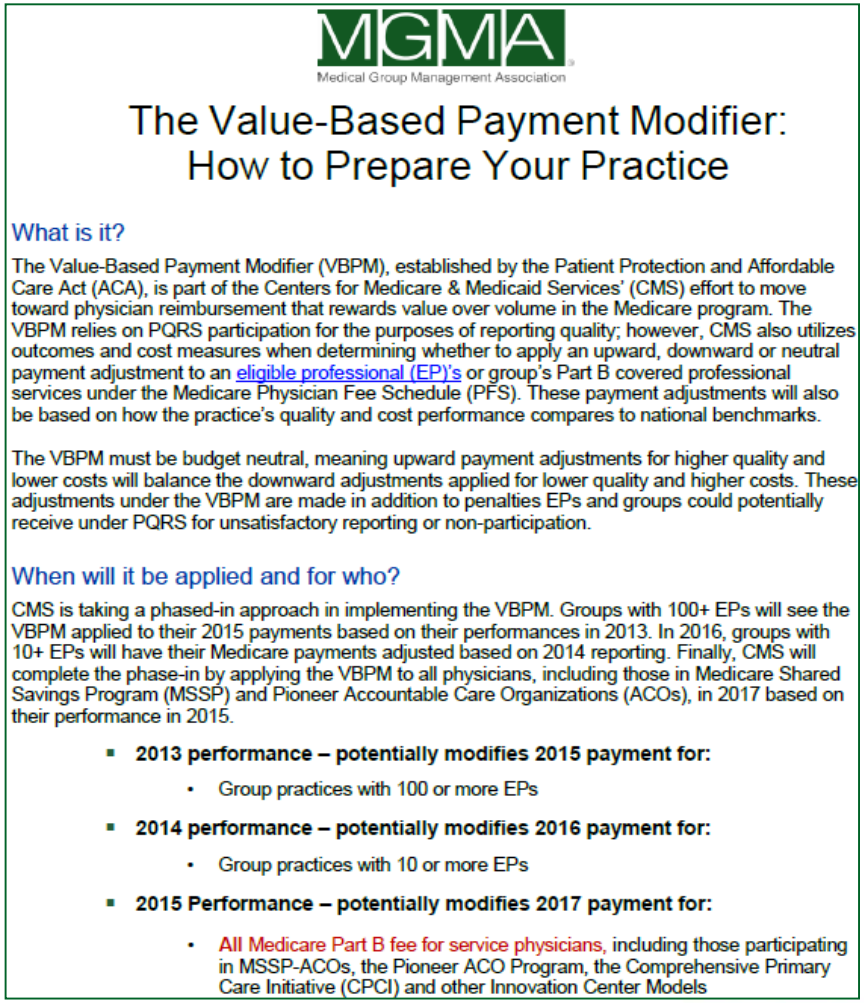
Take advantage of MGMA resources

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



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The Value-Based Payment Modifier: How to Prepare Your Practice

What is it?

The Value-Based Payment Modifier (VBPM), established by the Patient Protection and Affordable Care Act (ACA), is part of the Centers for Medicare & Medicaid Services' (CMS) effort to move toward physician reimbursement that rewards value over volume in the Medicare program. The VBPM relies on PQRS participation for the purposes of reporting quality; however, CMS also utilizes outcomes and cost measures when determining whether to apply an upward, downward or neutral payment adjustment to an eligible professional (EP)'s or group's Part B covered professional services under the Medicare Physician Fee Schedule (PFS). These payment adjustments will also be based on how the practice's quality and cost performance compares to national benchmarks.

The VBPM must be budget neutral, meaning upward payment adjustments for higher quality and lower costs will balance the downward adjustments applied for lower quality and higher costs. These adjustments under the VBPM are made in addition to penalties EPs and groups could potentially receive under PQRS for unsatisfactory reporting or non-participation.

When will it be applied and for who?

CMS is taking a phased-in approach in implementing the VBPM. Groups with 100+ EPs will see the VBPM applied to their 2015 payments based on their performances in 2013. In 2016, groups with 10+ EPs will have their Medicare payments adjusted based on 2014 reporting. Finally, CMS will complete the phase-in by applying the VBPM to all physicians, including those in Medicare Shared Savings Program (MSSP) and Pioneer Accountable Care Organizations (ACOs), in 2017 based on their performance in 2015.

- **2013 performance – potentially modifies 2015 payment for:**
  - Group practices with 100 or more EPs
- **2014 performance – potentially modifies 2016 payment for:**
  - Group practices with 10 or more EPs
- **2015 Performance – potentially modifies 2017 payment for:**
  - All Medicare Part B fee for service physicians, including those participating in MSSP-ACOs, the Pioneer ACO Program, the Comprehensive Primary Care Initiative (CPCI) and other Innovation Center Models

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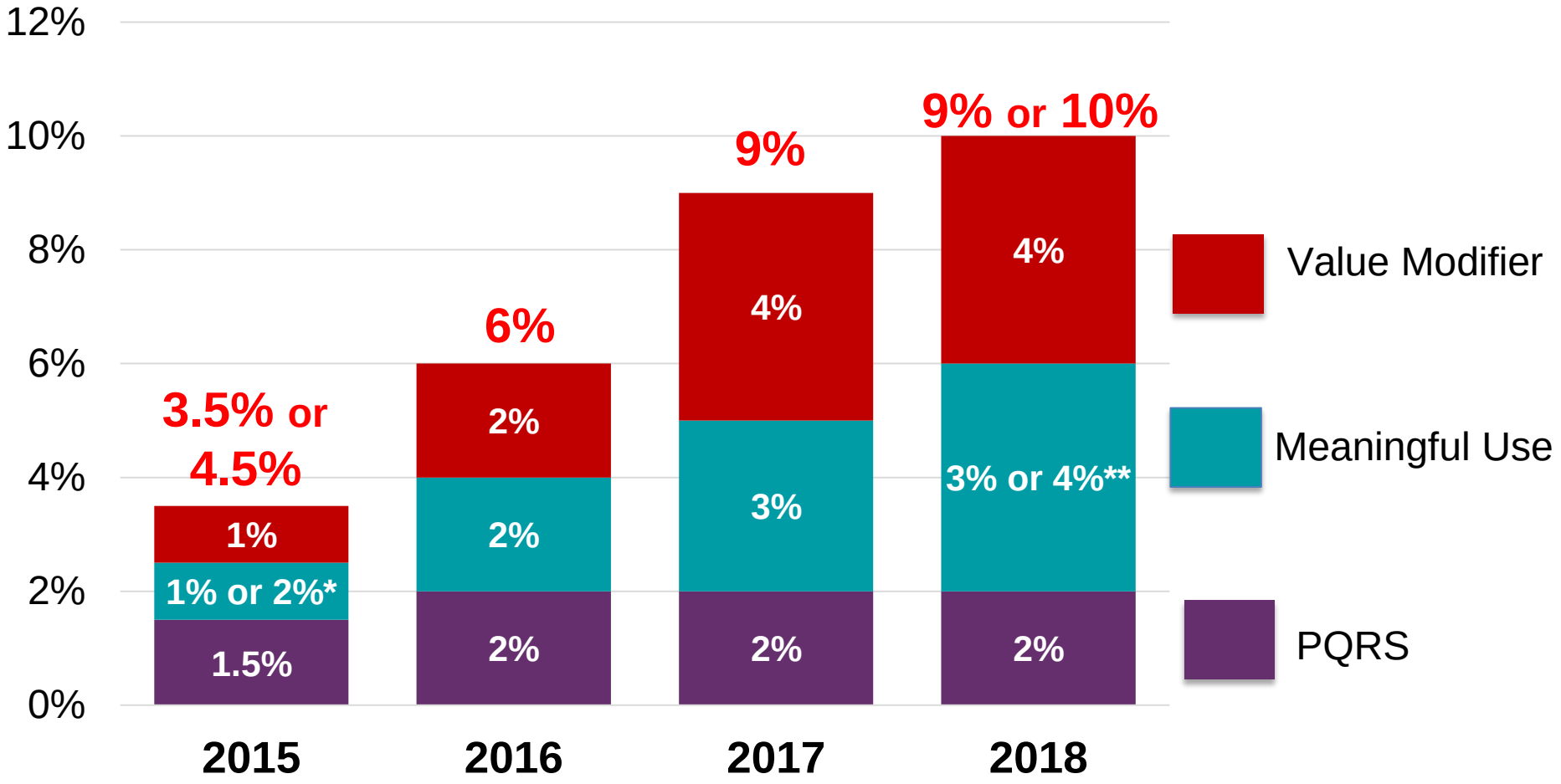
Maximum Medicare payment at risk



*EPs who were unsuccessful in MU and eRx will receive a 2% penalty in 2015

** Depends upon total number of EPs successful in meaningful use