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
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
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
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
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
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
Maximum Medicare payment at risk

- Value Modifier
- Meaningful Use
- PQRS

<table>
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<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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<tr>
<td>Value Modifier</td>
<td>3.5% or 4.5%</td>
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<td>9%</td>
<td>9% or 10%</td>
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<td>5%</td>
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<td>Meaningful Use</td>
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<td>0%</td>
<td>0%</td>
<td>6%</td>
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<tr>
<td>PQRS</td>
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<td>MIPS</td>
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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
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.
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!

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)

- 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

<table>
<thead>
<tr>
<th>Performance year</th>
<th>Modifier year</th>
<th>Impacted providers</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>
</tr>
<tr>
<td>2015</td>
<td>2017</td>
<td>All physicians</td>
</tr>
<tr>
<td>2016</td>
<td>2018</td>
<td>Physicians, PAs, NPs, CNSs and CRNAs</td>
</tr>
</tbody>
</table>

- 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”
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
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
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 [here](#).
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
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!
Questions?

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Appendix
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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
In 2017, all groups of physicians and solo practitioners

- Satisfactory 2015 PQRS Reporters
  - Register for GPRO or meet 50% individual EP reporting threshold
  - Avoid the 2017 PQRS penalty

- 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

Mandatory Quality Tiering Calculation

- Groups of physicians with 2-9 EPs and solo practitioners
  - Upward or neutral adjustment: 0% to +2x

- Groups of physicians with 10+ EPs
  - Upward, neutral or downward adjustment: -4% to +4x
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
# 2017 VBPM scoring under quality tiering calculation

<table>
<thead>
<tr>
<th><strong>Groups with 10+ EPs</strong></th>
<th><strong>Groups with 2-9 EPs and solo practitioners</strong></th>
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<tbody>
<tr>
<td><strong>Low quality</strong></td>
<td><strong>Low quality</strong></td>
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<tr>
<td><strong>Average quality</strong></td>
<td><strong>Average quality</strong></td>
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<tr>
<td><strong>High quality</strong></td>
<td><strong>High quality</strong></td>
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<tr>
<td><strong>Low cost</strong></td>
<td><strong>Low cost</strong></td>
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<td>0%</td>
<td>0%</td>
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<tr>
<td>+2.0x*</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>+4.0x*</td>
<td>+2.0x*</td>
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<tr>
<td><strong>Average cost</strong></td>
<td><strong>Average cost</strong></td>
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<tr>
<td>-2.0%</td>
<td>0%</td>
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<tr>
<td>0%</td>
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<tr>
<td>+2.0x*</td>
<td>+1.0x*</td>
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<td><strong>High cost</strong></td>
<td><strong>High cost</strong></td>
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<td>-4.0%</td>
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<td>-2.0%</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%
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
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](#)
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