Washington Update

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Agenda

• Current political outlook and SGR
• ACA implementation
• Proposed 2015 Medicare Physician Fee Schedule
• Federal quality reporting programs
• Compliance
Political Outlook and SGR

SGR

• Progress on SGR repeal ended with another patch – missed opportunity by Congress
• Congress averted the 24.1% cut to the SGR by passing the “Protecting Access to Medicare Act of 2014”
• Extends current 0.5% update through 2014 and provides a 0.0% freeze from Jan. 1 - Mar. 31, 2015
Affordable Care Act Implementation

ACA Implementation in 2014

- **State-based insurance exchanges**
  - 2015 open enrollment period: Nov. 15 – Feb. 15

- **Medicaid changes**
  - Learn more about state’s Medicaid expansions
  - Medicare/Medicaid Payment Parity
    - Raises some Medicaid payment rates to Medicare levels in 2013 and 2014
    - MGMA’s key points of final parity rule and CMS FAQ

- **Resources**
  - MGMA ACA Resource Center and Insurance Exchange Essentials for Practice Executives
  - Interactive implementation timeline for key ACA provisions
Administrative Simplification

- Health plans are required to offer new EFT and ERA standards as of Jan. 1
  - Credit card payments are not acceptable under this standard
  - Plans face significant fines if not compliant
- MGMA calls on CMS to address EFT abuses in a recent letter
- Member-benefit resources:
  - EFT and ERA guide
  - 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+ (or $100 aggregate during year) must be reported

<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>
</tbody>
</table>

- Information will be published on a public website in Sept. 2014
Sunshine Act or “Open Payments”

- Review and dispute process
  - Review/dispute period closed Sept. 10
  - To participate in future review periods, first register in the CMS Enterprise Portal

- MGMA comments on burdensome Open Payments review process. Request for CMS to delay publication of any data for six months.

- MGMA resources:
  - What you need to know about Open Payments
  - MGMA Sunshine Act webinar - on-demand edition
  - Physician Payments Sunshine Act member-exclusive memo

Proposed 2015 Medicare Physician Fee Schedule (MPFS)
Proposed 2015 MPFS

- Released July 11, final rule expected early November
- Includes proposed changes to Medicare physician payments for 2015 and adjustments to Medicare quality reporting programs (PQRS, VBPM)
- MGMA member benefit: comprehensive analysis of the proposed rule
- MGMA submitted comments urging CMS to make a number of changes to the proposed rule, particularly emphasizing the need to reduce onerous quality reporting burdens on practices

Proposed 2015 MPFS

Key proposals include:
- Evaluating 65 codes as potentially misvalued
  - MGMA comment: wait to review until CMS implements new process for evaluating misvalued codes
- Eliminating the use of 4,000 10 and 90-day global surgical codes
  - MGMA comment: withdraw this proposal and work with physician community to evaluate any necessary payment changes
- Adding additional information to the Physician Compare website (ex. PQRS measure performance)
  - MGMA comment: fix existing website flaws before adding anything else
Proposed 2015 MPFS

- Chronic Care Management (CCM) service includes non-face-to-face CCM for beneficiaries with 2+ chronic conditions; 20+ minutes per 30 days.
  - Many CCM service details were finalized in the 2014 MPFS. See our analysis for more information.
  - For 2015 CMS proposes:
    • RVU values: .61 work, .04 malpractice, .57 PE (approx. $43)
    • EHR certified to current MU certification criteria and remote access to electronic care plan for all care team members
    • Additional flexibility for incident to billing (would allow general supervision, even during regular office hours)
  - MGMA comments: utilize CPT code, finalize incident to changes, withdraw EHR requirement and clarify documentation expectations and use of auxiliary personnel

Federal Quality Reporting Programs
The **penalty** phase

<table>
<thead>
<tr>
<th>Year/Program</th>
<th>eRx</th>
<th>PQRS</th>
<th>Meaningful Use</th>
<th>Value Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>-1.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>-1.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>-2.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>-1.5%</td>
<td>-1.0%*</td>
<td>-1.0%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>2016</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>2017 - 2019</td>
<td>-2.0%</td>
<td>-3.0 – 5%** (each year)</td>
<td>Amount TBD</td>
<td></td>
</tr>
</tbody>
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* Penalties will be greater for unsuccessful e-prescribers

** Penalty amount could increase up to 5% depending on meaningful use success rates

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2014 Meaningful Use CEHRT final rule

- In response to MGMA's advocacy, CMS added much-needed flexibility in 2014 CEHRT final rule
  - Providers may use older EHR technology to report Stage 1 or Stage 2 objectives and corresponding clinical quality measures (CQMs)
  - Providers must attest to availability delays in fully implementing 2014-certified EHR technology
    - **Examples:** delays in software upgrades or patches, problems with software functionality, or safety issues
    - NOT financial issues, staff turnover, or EP's delay in upgrading
- Resources:
  - **New!** MGMA analysis of the final rule
  - CMS CEHRT interactive decision tool
Meaningful Use participation options in 2014

<table>
<thead>
<tr>
<th>If you were scheduled to demonstrate:</th>
<th>You would be able to attest for Meaningful Use*:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1 in 2014</td>
<td>2013 Stage 1 objectives and 2013 CQMs</td>
<td>2013 Stage 1 objectives and 2013 CQMs -OR- 2014 Stage 1 objectives and 2014 CQMs</td>
</tr>
<tr>
<td>Stage 2 in 2014</td>
<td>2013 Stage 1 objectives and 2013 CQMs</td>
<td>2013 Stage 1 objectives and 2013 CQMs -OR- 2014 Stage 1 objectives and 2014 CQMs -OR- Stage 2 objectives and 2014 CQMs</td>
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*Only EPs that could not fully implement 2014 Edition CEHRT for the EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability

Physician Quality Reporting System (PQRS) in 2014

Last year to earn a PQRS bonus: .5%
- To earn the bonus: report 9 measures, covering 3 National Quality Strategy (NQS) domains
  - For 50% of applicable patient population
- CMS 2014 PQRS Implementation Guide

Avoid the 2016 PQRS penalty: -2.0%
- To avoid the penalty: report 3 measures in 2014
  - For 50% of applicable patients (claims, registry reporting only)
  - OR meet bonus criteria (all other reporting options)
- 2016 penalty is based on 2014 reporting!
2014 PQRS Reporting Options

- **Deadline to register for GPRO reporting options:** **SEPT. 30**
  - CMS [memo](#) for how to register via [PV-PQRS](#) web portal
- Review measure [specifications](#) to ensure accurate reporting!
- MGMA/CMS 2014 PQRS requirements member-benefit [webinar](#)

**Individual EP reporting options**
- Claims
- Registry
- EHR
- New [Qualified Clinical Data Registry](#)

**Group Practice Reporting Options (GPRO)**
- GPRO registry
- GPRO EHR
- GPRO web interface
- New CMS-Certified Survey Vendor (CAHPS survey data)

MGMA PQRS/Value Modifier Survival Guide

**PQRS/Value-Modifier Survival Guide**

**SELECT A REPORTING OPTION:**
- Claims
- Electronic Health Record (EHR)
- Qualified Clinical Data Registry
- Web interface
- Registry
- Certified Survey Vendor (CAHPS)

Browse the reporting criteria associated with all reporting options to assist you in selecting the best reporting mechanism for your practice.

Access this member benefit [here](#)!
PQRS: Proposed Changes 2015 & beyond

• Proposed changes:
  – Increase reporting requirements from 3 measures to 9 measures for claims and registry reporting options
  – Require reporting of 2 cross-cutting measures for EPs that bill one or more face-to-face encounters
  – Would retire many existing measures, add new measures and measures groups, modify certain measures
  – Change informal review process to allow limited data corrections

• In our comment letter, MGMA urged CMS to:
  – Simplify PQRS criteria across all reporting options
  – Withdraw proposals to increase onerous program requirements
  – Expand informal review process to allow ALL eligible professionals and group practices to correct data errors

Where Quality & Cost Meet Payment…..
The Value-Based Payment Modifier
Value-Based Payment Modifier

• **What is it?** the VBPM will modify Part B payments based on quality & cost performance
• **Who is impacted?**

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• **What information is analyzed?**
  1. PQRS quality measures
  2. Outcomes measures: 3 composite measures on acute and chronic prevention quality indicators; all-cause readmission
  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

Value-Based Payment Modifier

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Value-Based Payment Modifier

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2016 Value Modifier: How it works

- **Satisfactory PQRS Reporters**
  - At the minimum, meet requirements for avoiding a 2016 PQRS penalty

- **Quality Tiering Calculation Based on Quality & Cost Performance**

- **Groups with 10+ EPs**
  - Upward or no adjustment (up to 2%)

- **Groups of physicians with 10-99 EPs**
  - Upward, neutral or downward adjustment up to +/-2%

- **Groups of physicians with 100+ EPs**
  - Upward, neutral or downward adjustment up to +/-2% in 2016

- **Non-Satisfactory PQRS Reporters**
  - -2% modifier in 2016 in addition to -2% penalty for PQRS in 2016
2016 Value Modifier: Next Steps

**NEXT STEPS** for impacted groups

- To avoid 2016 negative adjustments under the VBPM, a group must participate in PQRS in one of two ways:
  1. successfully report in 2014 PQRS GPRO (at a min. to avoid penalty), OR
  2. 50% of individuals meet reporting criteria individually (at a min. to avoid penalty)

**MGMA resources:**

- “Preparing your group for the 2016 VBPM” Sept. 11 webinar – [register](#) today!
- The VBPM: [How to Prepare Your Practice](#)
- PQRS-Value Modifier Survival Guide

2013 Quality & Resource Use Reports (QRURs)

- 2013 QRURs will contain quality of care and cost performance data for calendar year 2013 on measures that **WILL BE** used to compute the 2015 VBPM.
  - **Who’s eligible to receive a 2013 QRUR?**
    - **ALL** solo practitioners and group practices
  - **When will CMS make 2013 QRURs available?**
    - Still waiting! Expected to be released early September

- **Remember:** The 2015 VBPM will only impact groups of 100 or more EPs, but the 2013 QRURs give smaller groups a preview of how they may fare in future years under the modifier.

- Checkout [MGMA’s QRUR chart](#) for additional information and learn how to access past QRURs if your practice was eligible to receive one.
VBPM: Proposed Changes 2015 & beyond

- Proposed changes:
  - Apply to all physician and non-physician EPs, regardless of group size
  - Apply to EPs participating in the Medicare Shared Savings, Program, Pioneer Accountable Care Organization (ACO) Model, Comprehensive Primary Care (CPC) Initiative and other similar Innovation Center models and CMS initiatives.
  - Increase the maximum risk of payment adjustment from 2% in 2016 to 4% in 2017

- In our comment letter, MGMA:
  - Argues that at a minimum, CMS should focus on improving current program criteria before greatly expanding the program and doubling the amount of EP payment at risk
  - Calls on CMS to provide critical program guidance

Compliance
HIPAA Privacy & Security Omnibus Rule

- Sept. 23, 2013 compliance date for most provisions!
  - Final deadline to bring all BAAs into compliance: Sept. 22, 2014
- Key changes include:
  - Breach notification “harm standard” modified
  - Business associate responsibility expanded
  - Patient can ask for PHI electronically if practice stores it that way
  - Self-pay patients can require that PHI must not be disclosed to plan
- MGMA Resources:
  - New! HIPAA self-pay provision: What MGMA Members are Asking
  - New! “Laptops, Tablets, Smartphones and HIPAA: An Action Plan to Protect your Practice” – on-demand webinar
  - HIPAA Security Risk Analysis Toolkit
  - Sample BA agreement and sample NPP

ICD-10

New compliance date: Oct. 1, 2015

- CMS acknowledgement testing weeks:
  - November 17-21, 2014
  - March 2-6, 2015
  - June 1-5, 2015
- MGMA called on CMS to greatly expand to “end-to-end” testing
- Steps practices should take now:
  - Incorporate clinical documentation improvement
  - Inventory systems that could be impacted by change to ICD-10
  - Evaluate practice management software for sufficiency
- MGMA ICD-10 resources
Questions?

Appendix
Protecting Access to Medicare Act of 2014

• Additional changes in **SGR patch** include:
  – Extends the 1.0 work Geographic Practice Cost Index (GPCI) floor and therapy cap exceptions process
  – Delays the transition to ICD-10
  – Creates new Medicare policies for clinical diagnostic laboratory tests
  – Puts in place "appropriate use" criteria for certain imaging services
  – Creates a new process for identifying "misvalued codes" in the Medicare Physician Fee Schedule

ACA Implementation

**Resources**

• MGMA ACA Resource Center
• MGMA member benefit: Insurance Exchange Essentials for Practice Executives
• MGMA/AMA 2014 ACA exchange checklist
• HHS website on ACA and factsheet for providers
• Interactive implementation timeline for key ACA provisions

**Advocacy**

• Ongoing evaluation of new ACA regulations
• Continued discussions with HHS and CMS on key practice concerns
Medicare claims data release

- CMS released 2012 Medicare Part B physician claims data
  - Result of a federal court decision vacating an injunction that prevented CMS from making the data publicly available
- **Data** include: name, address, NPI, credentials, HCPCS code, place of service, utilization, Medicare payment, and submitted charges
- MGMA continues to express our concerns to CMS about the potential unintended consequences of this data release
  - Joint letter to CMS: ensure accuracy of the information, establish proper privacy safeguards, and provide context to prevent beneficiary confusion
- **MGMA resource:** [Key Details on Medicare Claims Data Release](#)

Medicare ordering/referring edits

- **Phase 2 effective since Jan. 6 – claims not meeting criteria will be denied**
- Applies to ordered/referred items and services billed by Medicare Part B suppliers (DMEPOS, clinical lab and imaging services, home health claims)
- Ordering/referring providers must be eligible to order or refer in Medicare, legal name & NPI must be listed on the claim, and they must have an enrollment record in Medicare
  - [Medicare Ordering and Referring file](#): check ordering/referring providers
- **Updated member resource:** [MGMA and AMA Ordering/Referring Factsheet](#)
Avoid a 2015 Meaningful Use Penalty

2015 meaningful use payment adjustment: -1.0%

• Three ways to avoid this penalty*
  1. Meaningful user in 2013: demonstrate MU and attest by March 31
  2. New meaningful user in 2014: demonstrate MU for 90 days and attest by Oct. 1
  3. Apply for a hardship exception by July 1
    • Hardship exceptions include:
      – New eligible professionals
      – Unforeseen circumstances
      – EPs who practice at multiple locations and lack control over availability of the CEHRT for >50% of patient encounters
      – Difficulties with EHR software vendor

*Anesthesiology, radiology, and pathology are excluded from penalties and do not have to apply for a hardship exception

Value Modifier: Overview of the score

What is the Value Modifier score composed of?

1) Quality measures
   • PQRS GPRO measures or individual measures reported by 50% of EPs individually
   • Optional for groups with 25+ EPs: CG-CAHPS patient experience of care measures

2) Outcomes measures
   • 3 composite measures on: acute and chronic prevention quality indicators; all-cause readmission

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 new Medicare Spending Per Beneficiary
   • Risk adjusted and standardized to eliminate geographic variation
   • Adjusted for specialty mix of the EPs within the group (new!)
**2012 Quality & Resource Use Reports (QRURs)**

**QRURs**: include comparative performance data on cost and quality measures and preview outcome under the Value Modifier

- **QRURs** based on 2012 data are available to groups with 25+ EPs
  - CMS’s [Quick Reference Guide](#) for accessing your 2012 QRUR

- **Value Modifier highlights from 2012 QRURs:**

<table>
<thead>
<tr>
<th>Quality/Cost</th>
<th>Low cost</th>
<th>Average cost</th>
<th>High cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average quality</td>
<td></td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Low quality</td>
<td></td>
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**Physician Compare**

A [website](#) with information about providers in the Medicare program