2018 Washington Update

Drew Voytal, MPA
Associate Director

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

**APRIL 3, 2018**
2017 MIPS data submission period closed

**APRIL 4 – JUNE 30, 2018**
CMS provides preliminary feedback

**JULY 1, 2018**
MIPS final score and feedback will be available

**JAN. 1, 2019**
CMS begins applying payment adjustments to each Part B claim
## 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</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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>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>
In 2018, clinicians will need to verify their MIPS participation at the QPP website.

CMS will not be mailing notices this year.

MGMA has pressed CMS since the start of the year to release this information. Because of this delay, we are strongly advocating for a return to 90 day reporting for all MIPS performance categories.

For your 2018 MIPS participation status, visit: qpp.cms.gov/participation-lookup
MIPS Group Participation in 2018

A group is 2 or more eligible clinicians. Each eligible clinician participating in MIPS via a group will receive the same adjustment based on the groups 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

(Options vary based on performance category)

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 (IA).
A group reporting to MIPS might have clinicians who, by themselves, are not eligible to participate in MIPS due to these three scenarios:

- Newly Enrolled in Medicare
- Qualified APM Participant
- Below Low-Volume Threshold

In group reporting, clinicians who are newly enrolled in Medicare, or are Qualified APM Participants (QPs), are still excluded from MIPS. Payment adjustments to group will not apply to these clinicians.

However, if the group exceeds the low-volume threshold clinicians who themselves fall below the low-volume threshold are included and must report MIPS data.
Groups must register to use the CMS Web Interface and/or CAHPS for MIPS Survey by June 30, 2018

Only groups of 25 or more eligible clinicians can report via the CMS Web Interface. Groups that participate in MIPS through qualified registry, qualified clinical data registry, or electronic health record (EHR) data submission mechanisms do not need to register.

All other sized groups can participate in the CAHPS for MIPS survey.

Register at the Quality Payment Program [website](#) between April 1, 2018 through June 30, 2018.

Please note, if your group was registered to participate in MIPS in 2017 via the CMS Web Interface, CMS automatically registered your group for 2018 CMS Web Interface participation. You may edit or cancel your registration at any time during the registration period. Automatic registration does not apply to the CAHPS for MIPS survey.
MIPS Year 2 – 2018

How to Get to 100 Points

- Quality: 50 points
- Cost: 10 points
- Advancing care information: 25 points
- Improvement activities: 15 points

MIPS Final Score: 0-100 points

Minimum Performance Period:
- 12 Months
- 12 Months
- 90 Days
- 90 Days

See Appendix for more information on MIPS Performance Categories
2018 MIPS Payment Adjustments

Final MIPS score in 2018: 0-100 points

Payment adjustment in 2020

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

15 points = break even point

70 points = exceptional bonus

≤ 3 points = -5% reduction
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 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: 5 POINTS

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

*CMS will apply a complex patient bonus capped at 5 points using the dual eligibility ratio and average Hierarchical Condition Category (HCC) risk 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.
2018 MIPS Scoring Example

**SMALL GROUP PRACTICE**

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACI</td>
<td>Report no data</td>
<td>Exempted</td>
</tr>
<tr>
<td>COST</td>
<td>50% Performance Score</td>
<td>5 Points</td>
</tr>
<tr>
<td>QUALITY</td>
<td>5% Performance Score</td>
<td>3.75 Points</td>
</tr>
<tr>
<td>IMPROVEMENT ACTIVITIES</td>
<td>50% Performance Score</td>
<td>7.5 Points</td>
</tr>
<tr>
<td></td>
<td>Complex patient bonus (up to 5 points)</td>
<td>3 points</td>
</tr>
<tr>
<td></td>
<td>Small practice bonus</td>
<td>5 points</td>
</tr>
</tbody>
</table>

**Hardship Exception 0**

**Complex patient bonus (up to 5 points)**

**Small practice bonus**

**Final MIPS Score 24.25 points**
## 2018 MIPS Scoring Example

**Medium Group Practice**

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACI</strong></td>
<td>100% Performance Score</td>
<td>25</td>
</tr>
<tr>
<td><strong>COST</strong></td>
<td>50% Performance Score</td>
<td>5</td>
</tr>
<tr>
<td><strong>QUALITY</strong></td>
<td>75% Performance Score</td>
<td>37.5</td>
</tr>
<tr>
<td><strong>IMPROVEMENT ACTIVITIES</strong></td>
<td>100% Performance Score</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Complex patient bonus (up to 5 points)</td>
<td>3 points</td>
</tr>
<tr>
<td></td>
<td>Small practice bonus</td>
<td>0 points</td>
</tr>
</tbody>
</table>

**Final MIPS Score:** 85.5 points

- 100% Performance Score: 37.5 points
- 50% Performance Score: 5 points
- 25 Points
- Final MIPS Score: 85.5 points
- Complex patient bonus (up to 5 points)
- Small practice bonus

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2018 MIPS Scoring Example

MIPS APM

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

Complex patient bonus
0 points

Small practice bonus
0 points

Final MIPS Score
55 points

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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>

! = not currently accepting new applicants
* = New opportunity in 2018

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

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
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
2018 PFS Calculation

Total RVUs from fee schedule

Conversion factor

Adjusted for:
- Complexity of service and expenses
  - Work RYU
  - FE RYU
  - PI RYU

Geographic factors
- Work GPCI
- FE GPCI
- PI GPCI

Payment modifier

Adjusted fee schedule payment rate

Policy adjustments (multiplicative)

Adjusted fee schedule payment rate

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

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### 2018 Key Policies in PFS

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-excepted, off-campus provider-based hospital outpatient department payment rates equivalent to 40% of OPPS payment rate (down from 50% in 2017).</td>
<td>Adjustment will level playing field between hospitals and physician practices.</td>
</tr>
<tr>
<td>Mandatory consultation of appropriate use criteria for advanced imaging services</td>
<td>delayed until 2020.</td>
</tr>
<tr>
<td>MACRA patient relationship HCPCS modifiers may be voluntarily reported</td>
<td>beginning Jan. 1.</td>
</tr>
<tr>
<td>Medicare Diabetes Prevention Program starts April 1.</td>
<td></td>
</tr>
</tbody>
</table>
## Retroactive 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.
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.

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

**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.
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
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, CMA will:

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

• Generate a new unique MBI for a Medicare beneficiary 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**
Practices have now adopted EHRs (75%+)
Focus of technology has been on meeting govt reporting requirements (Meaningful Use/QPP), not on HIPAA Security
Wannacry/Petya/Allscripts attacks make front page news
Patients increasingly worried about losing their sensitive information
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 performance category for the third, fourth and fifth years of MIPS.
- Allows CMS to reweight the cost performance category to not less than 10 percent for the third, fourth, and fifth years of MIPS.
- Allows CMS flexibility in setting the performance threshold for years three through five to ensure a gradual and incremental transition to the performance threshold set at the mean or median for the sixth year.
- Allows the Physician Focused Payment Model Technical Advisory Committee (PTAC) to provide initial feedback regarding the extent to which models meet criteria and an explanation of the basis for the feedback.

Reducing EHR Significant Hardship:

Removes the current mandate that meaningful use standards become more stringent over time. This eases the burden on physicians as they would no longer have to submit and receive a hardship exception from HHS.
Bipartisan Budget Act of 2018
Passed into law on February 9, 2018

Additional 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:

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 2010-2016. Extending it would lead to more across-the-board cuts to Medicare payments. Urge your members of Congress not to cut Medicare payments to physicians.
MGMA Advocacy at Work for Practices

MGMA Advocacy in 2018

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

- Preserving the in-office ancillary exception under the Stark law
- Stopping the sequester cuts to Medicare
- Medical liability reform
- Making MIPS simpler and more predictable

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
- Medicare Red Tape Relief Project with House W&M committee
- Red Tape Roundtable with House W&M committee

Visit our Contact Congress Portal and lend your voice.

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

Drew Voytal, MPA
Associate Director

MGMA Government Affairs
dvoytal@mgma.org
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

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

**Consider implications of group reporting**

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.

**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
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