Washington Update
Presented by MGMA Government Affairs

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HIPAA

Phase 2 audits: On-site or much more common desk audits; Have 10 business days within receipt of email to submit requested info to OCR via online portal

MGMA resources: MU FAQs & Security Risk Analysis Toolkit
Action step: Check spam for emails from OSOCRAudit@hhs.gov

Unreasonable fees: Lookout for increasingly common "virtual credit card” fees or EFT “value-add service” fees of 1-3%

MGMA resources: EFT/ERA Guide; Sample Letter to request EFT $$
Action steps:
✓ Request an EFT payment
✓ Stand firm against fees; Cite HIPAA regulations
✓ Lodge a formal complaint with OCR or through MGMA
2017 Proposed Medicare Physician Fee Schedule
Proposed CY 2017 Conversion Factors

**TABLE 41: Calculation of the Proposed CY 2017 PFS Conversion Factor**

<table>
<thead>
<tr>
<th>Conversion Factor in effect in CY 2016</th>
<th>35.8043</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update Factor</td>
<td>0.50 percent (1.0050)</td>
</tr>
<tr>
<td>CY 2017 RVU Budget Neutrality Adjustment</td>
<td>-0.51 percent (0.9949)</td>
</tr>
<tr>
<td>CY 2017 Target Recapture Amount</td>
<td>0 percent (1.0000)</td>
</tr>
<tr>
<td>CY 2017 Imaging MPPR Adjustment</td>
<td>-0.07 percent (0.9993)</td>
</tr>
<tr>
<td>CY 2017 Conversion Factor</td>
<td>35.7751</td>
</tr>
</tbody>
</table>

**Update factor:** Statutory update of +0.5% mandated under MACRA

**Budget neutrality adjustment factor:** RVUs changes may not cause total Medicare expenditures to differ by more than $20 million adjustments

**Target recapture amount:** Adjustments to misvalued code must reduce annual PFS expenditures by target of 0.5% of total PFS charges

**MPPR adjustment:** Effective Jan. 1, 2017, the PC of advanced imaging services will be reduced from 25% to 5% under the MPPR

**Estimated Impact on CY 2017 Payments for Certain Specialties (Table 43)**

**Specialty Impacts Exceeding +/- 2%**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional radiology</td>
<td>-7%</td>
</tr>
<tr>
<td>Independent laboratory</td>
<td>-5%</td>
</tr>
<tr>
<td>Family practice</td>
<td>+3%</td>
</tr>
</tbody>
</table>
Key Takeaways

• Public release of additional Part D, MA and MLR data
• Expansion of the Diabetes Prevention Program (starts Jan 1)
• MSSP changes, including voluntary beneficiary assignment, quality reporting updates & future alignment with MIPs/APMs
• Requiring providers and suppliers to be enrolled in Medicare in order to contract with MA health plans
• 2nd round of appropriate use criteria for diagnostic imaging, incl. new proposals for clinical priority areas, updates to CDS requirements/application process & new hardship exceptions
• New codes added to list of eligible telehealth services, including dialysis and advanced care planning services

*Advocacy win for MGMA
Key takeaways (cont.)

• Establishes in rulemaking how VM quality & cost composites would be affected if payment determination changes after informal review or “unanticipated issues arise”
  *Advocacy win for MGMA

• Various coding and payment changes, including:
  – New reimbursable codes for treating dementia, behavioral health conditions, prolonged E&M services, and patients with limited mobility
  – Billing changes to CCM services to reduce admin burden and provide additional reimbursement for treating complex cases
  *Advocacy win for MGMA
Visit:
mgma.org/Medicare-reimbursement

• **2016 Medicare Physician Fee Schedule Analysis**
• **2016 Medicare Update Free On-Demand Webinar**

*Stay tuned for the 2017 Proposed PFS Analysis and other CY 2017 tools and resources!*
Current federal quality reporting programs
### Medicare penalty risk

**Based on 2016 performance**

<table>
<thead>
<tr>
<th>Practices</th>
<th>Meaningful Use</th>
<th>PQRS</th>
<th>VBPM*</th>
</tr>
</thead>
<tbody>
<tr>
<td>of 10+ EPs</td>
<td>3-4%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Maximum:</strong></td>
<td></td>
<td></td>
<td><strong>-10%</strong></td>
</tr>
<tr>
<td>of 9 or fewer EPs</td>
<td>3-4%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Maximum:</strong></td>
<td></td>
<td></td>
<td><strong>-8%</strong></td>
</tr>
</tbody>
</table>

*There are equivalent bonuses available under the Value-Based Payment Modifier.*
PQRS
(Physician Quality Reporting System)
PQRS in 2016

• **2% automatic penalty** in 2018 for failing to report in 2016

• Consistent with 2015 reporting criteria: **most** reporting options require **9** quality measures that span at least **3** NQS domains
  – Plus a **cross-cutting measure requirement** for claims & registry reporting

• **281** total PQRS measures; **18** GPRO web interface measures

• Measures have changed in 2016 so make sure to view the **2016 PQRS measures list**, which is sortable by reporting mechanism, NQS domain, and more.

• QCDR reporting is now available under GPRO

• GPRO registration deadline was June 30; providers may still report as individuals
VBPM

(Value-Based Payment Modifier)
VBPM

- **Step 1: Automatic penalty or quality tiering adjustment?**
  - Unsuccessful PQRS reporters: -2% or -4% automatic penalty
  - Successful PQRS reporters: -4% to +4x quality-tiering $$ adjustment

- **Step 2: Calculate practice’s total composite score**

<table>
<thead>
<tr>
<th>Quality Composite Score (50%)</th>
<th>Cost Composite Score (50%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- PQRS measures</td>
<td>- Per capita cost</td>
</tr>
<tr>
<td>- Preventable hospital admissions/readmissions</td>
<td>- Medicare spending per beneficiary</td>
</tr>
<tr>
<td></td>
<td>- Per capita cost for chronic conditions</td>
</tr>
</tbody>
</table>

- **Step 3: Compare to national average & adjust payments**

<table>
<thead>
<tr>
<th>9 EPs or fewer</th>
<th>Low quality</th>
<th>Avg. quality</th>
<th>High quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost</td>
<td>0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average cost</td>
<td>-1.0%</td>
<td>0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High cost</td>
<td>-2.0%</td>
<td>-1.0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10 or more EPS</th>
<th>Low quality</th>
<th>Avg. quality</th>
<th>High quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost</td>
<td>0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
</tr>
<tr>
<td>Average cost</td>
<td>-2.0%</td>
<td>0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>High cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
2016 VBPM Payment Adjustments
Based on 2014 cost and quality data

13,813 groups of 10+ EPs are impacted

0.9%
(128 practices)
QT bonus of
+15.92% or +31.84%

39.2%
(5,418 practices)
auto 2% penalty

59.4%
(8,208 practices)
Neutral QT adjustment

0.4%
(59 practices)
QT penalty of
-1% or -2%

Source: CMS’ fact sheet on 2016 VBPM results
VBPM in the 2016 performance year

Expands the VBPM to PAs, NPs, CNSs and CRNAs

Subjects groups of 9 or less EPs to a 2% quality-tiering penalty
> Makes no change to penalties for groups of 10 or more EPs

Exempts a practice if at least 1 billing EP participates in one of five specified APMs (Oncology Care Model, Next Gen ACOs, Pioneer ACOs, Comprehensive ESRD Care Initiative, CPCI)

**Action Step:**

1. Download your 2014 final and 2015 mid-year QRURs (just released in April) from the CMS Enterprise Portal.

2. Stay tuned to the *Washington Connection* for news about your 2015 final QRURs, expected sometime this Fall.

3. Visit mgma.org/QRUR for more information.
QRURs (Quality and Resource Use Reports)

Your group’s VBPM report card!

2014 Final QRURs
- Includes full breakdown of cost and quality performance metrics
- Shows how your practice compares to national averages
- Provides your practice’s 2016 VBPM cost adjustment info

2015 Mid-Year QRURs
- Progress report
- For informational purposes only
- Include cost and quality outcomes measures, not PQRS.

Visit: mgma.org/QRUR
Meaningful Use
MU Stage 2: Key 2016 changes

Reporting period

- Full-year reporting in 2016, with a limited exception for new EPs
- Proposed CY17 OPPS proposed rule included 90-day EHR reporting in 2016!

10 core reporting objectives (incl. new public health obj.)

- Previously 17 core and 3 menu objectives
- Redundant and “topped out” objectives were eliminated

Reduced “patient action” measure thresholds

- Patient electronic access (view, download, transfer) objective
  5% of patients 1 patient (at least 50% provided access)
- Secure messaging objective
  5% patients 1 patient (up from demonstrating capability in 2015)
New EHR Product Transparency

• New OCR website provides each EHR developer's mandatory disclosure statement and transparency attestation, which verifies that the costs and performance of its products and services are visible to the public.

• Under the new requirements, developers must fully disclose all known material types of costs and limitations—including technical and contractual restrictions—that a practice may encounter when implementing or using the developer's technology.

• These new disclosures are designed to help practices better understand the capabilities and limitations of health IT products during the purchasing process.
How are quality reporting adjustments applied?

<table>
<thead>
<tr>
<th>PQRS</th>
<th>VBPM</th>
<th>MU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique NPI/TIN combination</td>
<td>TIN (practice) level</td>
<td>NPI (provider) level</td>
</tr>
<tr>
<td>Adjustment is not applied if NPI/TIN</td>
<td>Adjustment stays with practice</td>
<td>Adjustment follows provider</td>
</tr>
<tr>
<td>combination no longer exists</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*MGMA resource:
How Medicare penalties apply to providers who switch practices
Visit:
mhma.org/federalqualityreporting

- **Meaningful Use Overview: 2015-2017**
- **2016 PQRS-Value Modifier Survival Guide**
- **2016 VBPM: Prepare Your Practice**
- **MGMA’s QRUR Resource Webpage**
MACRA

(Medicare Access and CHIP Reauthorization Act)
MACRA: A two pathway model

MIPS

APMs
The regulatory process

1. Law is passed requiring rulemaking
2. Department issues a proposed rule
3. Public Comment Period
4. Department reviews comments, makes modifications
5. Department issues final rule
Current programs

- Meaningful use
- Value-based payment modifier
- PQRS

MIPS

- Advancing care information (ACI)
- Resource use (aka quality)
- Cost
- Clinical practice improvement activities

New

Meaningful use

Value-based payment modifier

PQRS

Quality

Cost
Quality reporting: *Then and now*

**PQRS, VBPM, MU**

- Max cumulative penalties of up to 11% in 2016
- Scores evaluated on all-or-nothing basis
- No budget neutrality requirements; only VBPM features upside risk
- 3 separate programs…

**MIPS**

- Max penalty of 4% in 2017
- Scores must be evaluated on a “sliding scale”
- Dual-sided risk (excepting “exceptional performance” bonuses)
- 1 program with 4 performance categories…
MIPS performance category weights in 2019*

- Resource use (aka quality): 50%
- Advancing care info (EHR use): 25%
- CPIA: 15%
- Cost: 10%

*CMS has broad authority to reweight these categories and weights change over time.
APMs (Alternative Payment Models)

What we know from MACRA

- Under MACRA, “eligible” APMs must:
  - Base payment on quality measures comparable to MIPS;
  - Require use of certified EHRs; and
  - Bear more than “nominal financial risk” (left undefined)
    …OR be a medical home model.
APMs (Alternative Payment Models)

What we know from MACRA

• To be considered a qualified APM and earn incentives, a certain % of a practice’s billable services must be furnished through the APM.
  • 2019-2020: 25% of Medicare $$
  • 2021-2022: 50% of Medicare $$ OR 50% of all-payer $$ AND 25% of Medicare $$

• Practices can also be considered “partially qualified” APMs if they meet a slightly lower threshold.
  – 2019-2020: 20% of Medicare $$
  – 2021-2022: 40% of Medicare $$ OR 40% of all-payer $$ AND 20% of Medicare $$

* Secretary may establish similar patient thresholds for each
APMs (Alternative Payment Models)

What we know from MACRA

- Qualifying participants in “eligible” APMs receive:
  - Exemption from MIPS;
  - 5% annual lump sum bonus payments through 2023; and
  - 0.5% higher fee schedule update from 2026 onward.

- Partially qualifying APM participants receive:
  - The option to forego participating in MIPS.
  - Favorable scoring in MIPS.
### Medicare payments under MACRA

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline PFS Updates</th>
<th>MIPS*</th>
<th>APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>0.5%</td>
<td>±4%</td>
<td>5% lump sum bonus</td>
</tr>
<tr>
<td>2017</td>
<td>0%</td>
<td>±5%</td>
<td>0%</td>
</tr>
<tr>
<td>2018</td>
<td>±7%</td>
<td>±9%</td>
<td>+0.5% PFS</td>
</tr>
<tr>
<td>2019</td>
<td>+10% bonus for exceptional performance**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>±9%</td>
<td>±7%</td>
<td>±9%</td>
</tr>
<tr>
<td>2021</td>
<td>+10% bonus for exceptional performance**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>±7%</td>
<td>±5%</td>
<td>±4%</td>
</tr>
<tr>
<td>2023</td>
<td>±5%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>2024</td>
<td>±4%</td>
<td>±5%</td>
<td>±4%</td>
</tr>
<tr>
<td>2025</td>
<td>±5%</td>
<td>±7%</td>
<td>±7%</td>
</tr>
<tr>
<td>2026</td>
<td>±7%</td>
<td>±5%</td>
<td>±5%</td>
</tr>
</tbody>
</table>

*Potential 3x scaling adjustment but unlikely

** Up to $500 million/year
MIPS and APMs proposed rule
On April 27, CMS released a major proposed rule to implement the MIPS and APMs provisions of MACRA.
MIPS Eligible Clinicians

• In 2017-2018, eligible clinicians (ECs) include:
  – Physician
  – Physician assistant
  – Nurse practitioner
  - Certified nurse practitioner
  - Certified registered nurse anesthetists

• CMS has the legislative authority to expand this list in future years. It did not do so in this proposed rule, but expressed plans to address this in future rulemaking.

• The following types of ECs would be excluded from MIPS:
  – Qualifying APM participant
  – Partial qualifying APM participant who opts out of MIPS
  – Newly-enrolled in Medicare
  – Does not exceed low volume threshold *(ECs or groups that have $10,000 or less in Medicare $ and 100 or less Medicare patients)
MIPS & APMs Proposed Rule

Timing Takeaways

CMS Proposals:
- Jan. 1, 2017 start date
- Full calendar reporting year
- 2-year lookback between performance and payment years
- Feedback on annual basis

MGMA recommendations:
- Establish a realistic start date to provide practices and vendors with adequate time to prepare, no earlier than Jan 1, 2018
  - Andy Slavitt recently said that an alternative start date is an option being considered by the Agency to improve industry readiness
- Reduce reporting period to 90 days or another stat. valid window
- Shrink the two-year lag between performance and payment
- Increase relevance and timeliness of feedback, such as a quarterly basis, which was recommended by Congress in MACRA
MIPS: Quality

- 200+ measures to choose from, each evaluated on a decile performance scale
- ECs and groups report 6 measures, down from 9 in PQRS
  - Must include one outcome and one cross-cutting measure
- CMS will also calculate 3 population-based measures using claims for groups with 10+ ECs
- Total of 60-90 points, depending on practice size
- Substantially increased reporting thresholds
  - Claims: 80% of all Medicare Part B patients
  - Registry, EHR, QCDR: 90% of all patients (all payers)
  - Web interface: 248 assigned patients (same as PQRS)
MGMA’s position

• CMS should:
  – Substantially reduce increased data submission thresholds while maintaining robust statistical validity
  – Withdrawal outcome and cross-cutting measure requirement & reduce overall number of measures
  – Set achievable benchmarks on more current data (proposal would based benchmarks on data from four years prior to payment year)
  – Clarify the proposed process to identify whether groups have fewer than 6 applicable measures to report
MIPS: Resource use (aka cost)

- Replaces VBPM
- Calculated by CMS based on claims; no reporting required
- Measures include:
  - Total per capita costs (Parts A and B);
  - Medicare spending per beneficiary; and
  - 41 condition and treatment episode-based measures
- Each measure must have min 20 patient sample
- Composite score will average all scoreable measures
- Continued use of problematic patient attribution methodology from VBPM with limited tweaks
MGMA’s position

- **CMS should:**
  - Fix problematic VBPM patient attribution methodology
  - Withdrawal proposal to measure clinicians and groups on total cost of care and MSPB measures, which were developed to measure hospitals
MIPS: Advancing care information (ACI)

<table>
<thead>
<tr>
<th>MIPS category</th>
<th>Quality</th>
<th>Cost</th>
<th>EHR use</th>
<th>Practice improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 weight</td>
<td>50%</td>
<td>10%</td>
<td>25%</td>
<td>15%</td>
</tr>
</tbody>
</table>

• 2 primary, equally-weighted scoring components:

<table>
<thead>
<tr>
<th></th>
<th>Possible Points</th>
<th>Number of Objectives</th>
<th>Do I have to report each objective?</th>
<th>Category scoring</th>
<th>Measure scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Score</td>
<td>50</td>
<td>6</td>
<td>Yes; failing to report any base measure will result in an ACI score of 0</td>
<td>Cumulatively; all or nothing</td>
<td>Must meet threshold or answer yes/no as appropriate</td>
</tr>
<tr>
<td>Performance Score</td>
<td>50</td>
<td>8</td>
<td>No; you can report as little or as many measures as you</td>
<td>By indiv. measure; worth up to 10 points each</td>
<td>Decile scale based on performance</td>
</tr>
</tbody>
</table>

*Plus an available bonus point for public health registry reporting*
MGMA’s ACI concerns and position

• Concerns:
  – 2015 CEHRT required in 2018 (0 vendors so far)
  – 2 of 8 perf. measures are not available with 2014 CEHRT
  – 5 of 8 perf. measures depend on 3rd party actions

• Positions
  – Permit EC/group use of 2014 CEHRT well beyond the current 2018 mandate for 2015 CEHRT
  – Reduce/eliminate obj’s that require 3rd party action
  – Significantly simplify scoring methodology
  – Make base score = having & operating an EHR system
MIPS: Clinical practice improvement activities (CPIA)

- **New** performance category under MIPS
- Attest to any combination of proposed activities worth between 10-60 points to earn full score of 60 points
  - Most worth 10 or 20 points
- 90-day performance period

<table>
<thead>
<tr>
<th>MIPS category</th>
<th>Quality</th>
<th>Cost</th>
<th>EHR use</th>
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<td>15%</td>
</tr>
</tbody>
</table>

- PCMH accreditation                  | 60 points |
- APM participation                   | 30 points |
- 24/7 access to clinicians for urgent/emergent care | 20 points |
- Timely communication of test results | 10 points |
- Participation in an AHRQ patient safety organization | 10 points |
MGMA’s position

• CMS should:
  – Finalize 90-day reporting period and simple attestation process, which lessen admin burden (apply this to other performance categories)
  – Reduce total number of requirements, which could require up to 6 activities to get full credit
MIPS & APMs Proposed Rule

MIPS takeaways: The big picture

Criticisms:

• Extremely complex
  • Each category has its own distinct scoring methodology; point system
  • Various exceptions and reweighting of performance categories depending on participation in various models, APM designation, etc.

• Negative impact on small and medium size practices
## Table 26

### Estimated impact of MIPS payments by practice size

<table>
<thead>
<tr>
<th>Practice Size</th>
<th>Eligible Clinicians</th>
<th>Percentage likely to be penalized</th>
<th>Percentage likely to get bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo</td>
<td>102,788</td>
<td>87%</td>
<td>12.9%</td>
</tr>
<tr>
<td>2-9</td>
<td>123,695</td>
<td>69.9%</td>
<td>29.8%</td>
</tr>
<tr>
<td>10-24</td>
<td>81,207</td>
<td>59.4%</td>
<td>40.3%</td>
</tr>
<tr>
<td>25-99</td>
<td>147,976</td>
<td>44.9%</td>
<td>54.5%</td>
</tr>
<tr>
<td>100 or more</td>
<td>305,676</td>
<td>18.3%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Overall</td>
<td>761,342</td>
<td>45.5%</td>
<td>54.1%</td>
</tr>
</tbody>
</table>
MIPS & APMs Proposed Rule

MIPS takeaways: The big picture

MGMA recommendations:

• Don’t increase the reporting burden, which spreads practices with limited resources (i.e. small & rural practices) too thin.
  – Simplify and streamline scoring methodologies across categories
  – Reduce the total number of measures (up to 69 as proposed)
  – Increase opportunities to report one measure and earn credit for multiple categories
MIPS & APMs Proposed Rule

APMs Takeaways

• Establishes patient thresholds of 20% for full APMs and 10% for partially qualified APMs

• Creates new APM category called MIPS APMs; specifies APMs qualifying for incentives as “advanced APMs”

• Sets extremely narrow criteria for “nominal risk”:
  • Total risk is at least 4% of APM spending target
  • Marginal risk (aka sharing rate) is at least 30%
  • Minimum loss rate must not exceed 4%

• Which leaves a grand total of 6 advanced APMs for 2017…
## Proposed 2017 advanced APMs

<table>
<thead>
<tr>
<th>Model</th>
<th>Current Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSSP ACOs – Track 2</td>
<td>6</td>
</tr>
<tr>
<td>MSSP ACOs – Track 3</td>
<td>16</td>
</tr>
<tr>
<td>Next Gen ACO Model</td>
<td>18</td>
</tr>
<tr>
<td>Comprehensive ESRD Care Orgs</td>
<td>13</td>
</tr>
<tr>
<td>Comprehensive Primary Care Plus</td>
<td>Starts in 2017; limited to 20 geographic areas</td>
</tr>
<tr>
<td>Oncology Care Model (2-sided risk track)</td>
<td>Starts in 2018</td>
</tr>
</tbody>
</table>
MIPS APMs

• New additional category of APMs introduced in rule

• Criteria:
  (1) APM Entities participate in APM under agreement with CMS;
  (2) APM Entities include 1+ MIPS ECs on Participation List; and
  (3) APM bases $ on performance via cost/utilization & quality measures.

• May or may not also be an advanced APM

• Requirements, methodologies and MIPS performance category weighting would differ by model
MIPS & APMs Proposed Rule

MGMA’s recommendations for APMs

• Significantly expand what constitutes “nominal risk”
  • Include investment costs & care coordination activities
  • Calculate nominal risk based on professional service revenues, as opposed to total APM expenditures

• Drastically broaden the scope and number of qualified APMs
  • Look to the private sector & physician-focused payment models
  • “MIPS APMs” should be counted as fully qualified APMs
  • Institute a transparent, predictable process for reviewing future APM proposals from stakeholders

• Award more credit in MIPS for partially qualified APMs
MIPS & APMs Proposed Rule

Next steps for MGMA

• Participate in ongoing meetings with Administration, Congress, and other stakeholders.
• Represent physician practice voice on industry coalitions.
• Track final rule, expected this fall.
• Educate MGMA members on latest updates and continue to develop educational resources.
MIPS & APMs Proposed Rule

What physician practices can do now

✓ Remember this rule is PROPOSED
✓ Assess your practice’s performance under current programs
✓ Consider which path(s) are best suited for your practice
✓ Evaluate EHR and other vendor readiness and costs
✓ Explore clinical practice improvement opportunities
✓ Engage in ongoing learning about MACRA
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MACRA

BREAKING:

The Centers for Medicare & Medicaid Services released the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models proposed rule on April 27, 2016:

- Proposed rule (released on April 27, 2016)
- HHS press release (released on April 27, 2016)
- HHS Executive Summary (released on April 27, 2016)
- MIPS & APMs proposed rule fact sheet (released on April 28, 2016)
- Proposed MIPS EHR component fact sheet (released on April 28, 2016)
- Register for the May 3 CMS webinar: Overview of the MIPS & APMs proposed rule (announced on April 29, 2016)
- Register for the May 4 CMS webinar: Review of proposed MIPS program (announced on April 29, 2016)

What is MACRA?

After 17 years of uncertainty and threats of drastic cuts to physician payments, the flawed sustainable growth rate (SGR) formula was finally repealed in 2015 by the Medicare Access and CHIP Reauthorization Act (MACRA). But that was just the starting point. MACRA established a new future for Medicare payments, including two separate pathways toward quality-based reimbursement and a period of positive, stable Medicare payment updates.

Key elements of MACRA include:
And then there’s…
# 2016 election: Spotlight on Healthcare

<table>
<thead>
<tr>
<th>Hillary Clinton</th>
<th>Donald Trump</th>
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<td>Build on and modify existing ACA by increasing exchange tax credits, addressing the “family glitch,” and creating a public option, etc.</td>
<td>Repeal ACA; replace with private insurance market that operates across state lines; provide form of tax relief for insurance</td>
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MGMA’s Washington Connection provides the latest in regulatory and legislative news straight from the nation’s capital and helps you stay one step ahead of evolving federal requirements and deadlines.

A variety of member-benefit webinars, articles, online tools and downloadable resources help you navigate complex federal programs and decipher need-to-know information.

Expert MGMA Government Affairs staff are available to answer questions and offer guidance on healthcare policy issues.
Questions?
Acronyms reference guide

- ACO – accountable care organization
- APM – alternative payment model
- CAHPS - Consumer Assessment of Healthcare Providers and Systems
- CMS – Centers for Medicare & Medicaid Services
- CNS – certified nurse specialist
- CPCI – Comprehensive Primary Care Initiative
- CRNA – certified registered nurse anesthetist
- EFT – electronic funds transfer
- EHNAC – Electronic Healthcare Network Accreditation Commission
- EIDM - Enterprise Identity Management
- EHR – electronic health record
- EP – eligible professional
- ERA – electronic remittance advice
- ESRD – end-stage renal disease
- GPCI – geographic practice cost index
- GPRO – group practice reporting option
- HHS – U.S. Department of Health & Human Services
- IACS - Individuals Authorized Access to the CMS Computer Services
- ICD-10 - 10th revision of the International Statistical Classification of Diseases and Related Health Problems
- MIPS – Merit-Based Incentive Payment System
- NPs – nurse practitioners
- NQS – National Quality Strategy
- PA – physician assistant
- PFS – physician fee schedule
- PM – practice management
- PQRS – Physician Quality Reporting System
- QCDR – qualified clinical data registry
- QRUR – quality and resource use report
- RVU – relative value unit
- VBPM – Value-Based Payment Modifier