MDofficeManager

2017
Regulatory Update

There is a change in the wind

The System is Broken

- The basic operating premise is that FFS is no longer financially sustainable.
- America's healthcare system must move towards rewarding things other than volume
- Eventually reimbursement needs to incentivize keeping people healthy, rather than treating them after they get sick.
- Debatable over whether this is good or bad, but the economics seem to be driving the discussion rather than philosophical issues.

The Core Issue

- FFS isn't completely going away, but it will be increasingly augmented, if not out and out replaced, by something else
- Most common now is reduced FFS with "make up" payments for something else:
  - Quality / Performance (P4Q / P4P)
  - Cost Effectiveness
  - Coordinated care
  - Expanded services

The Core Issue

- However in some regions more dramatic changes
  - Capitation
  - Bundled payments for specific diagnostic situations
  - PMPM payments for enhanced primary care

Our Challenge

- Our systems need to handle new types of transactions and adjustments
- We need to have, if not enough knowledge to educate our clients, at least enough not to look stupid.

FFS Will Not Go Easily

- FFS is heavily entrenched culturally, legislatively, contractually and in the information systems that are the underpinnings of today's healthcare ecosystem.
- Question becomes: How to change? How fast can it be done without disrupting the ecosystem too much?

Common Non-FFS Approaches

Pay for Quality is Typically Step 1

- Set up arbitrary methods of measuring quality
- Collect data by provider (typically from claims data)
- Incentivize providers based on adherence to standards

Next is Measuring Value

- Set up arbitrary methods of measuring acuity
- Designate specific conditions to measure
- Collect data by provider (typically from provider's claims data, but may include data from other sources)
- Incentivize providers that provide good quality at low costs and penalize providers that provide poor quality at high cost.

Incentivize Adoption of New Processes

- EMR adoption (MU)
- Patient Centered Medical Home
- Payment for more preventive care
- Pay for expanded primary care
- Reward more convenient hours, shorter wait times, coordinated care with other providers

And Then There Is This Trump Guy

Uncertainty Increasing at the Moment

- Presumed ouster of Obamacare is likely to be disruptive to our clients and to some extent us
- Under ACA
  - About 33M more people with coverage
  - Laundry list of mandated covered services
  - Higher percentage of 3rd party payments
  - Increased uniformity in coverage across the country

The Murky Crystal Ball Says:

- Promises of "universal availability of coverage"
- Lower benefit levels
  - Less uniformity across the country as state minimums potentially exceed federal
- More "personal accountability"
  - Increased patient payments
- Medicaid more varied across states
- Sale of insurance across state lines?
- Demand for price transparency

What Can We Discern Based On Appointments?

- Tom Price – Head of DHHS
  - Ortho Surgeon
  - Fierce opponent of Obamacare
  - Anti-MACRA, although unlikely to attempt to overturn it
  - Isn’t likely to provide push-back to Trump
- Seema Verma – Head of CMS
  - Consultant. Primarily known for working with Medicaid programs
  - Helped forge Indiana’s program for Pence
  - Patient contributions required and if payment missed then dismissal from program for six months

Examples of Reimbursement Changes

- Federal
  - Has been MU, PQRS and VBM
  - Now MACRA
  - Also CPC+,
- Local
  - Hawaii as an example
  - Virtually all PCPs will now be paid by capitation for 70% of their patients

The Recent CMS Approach

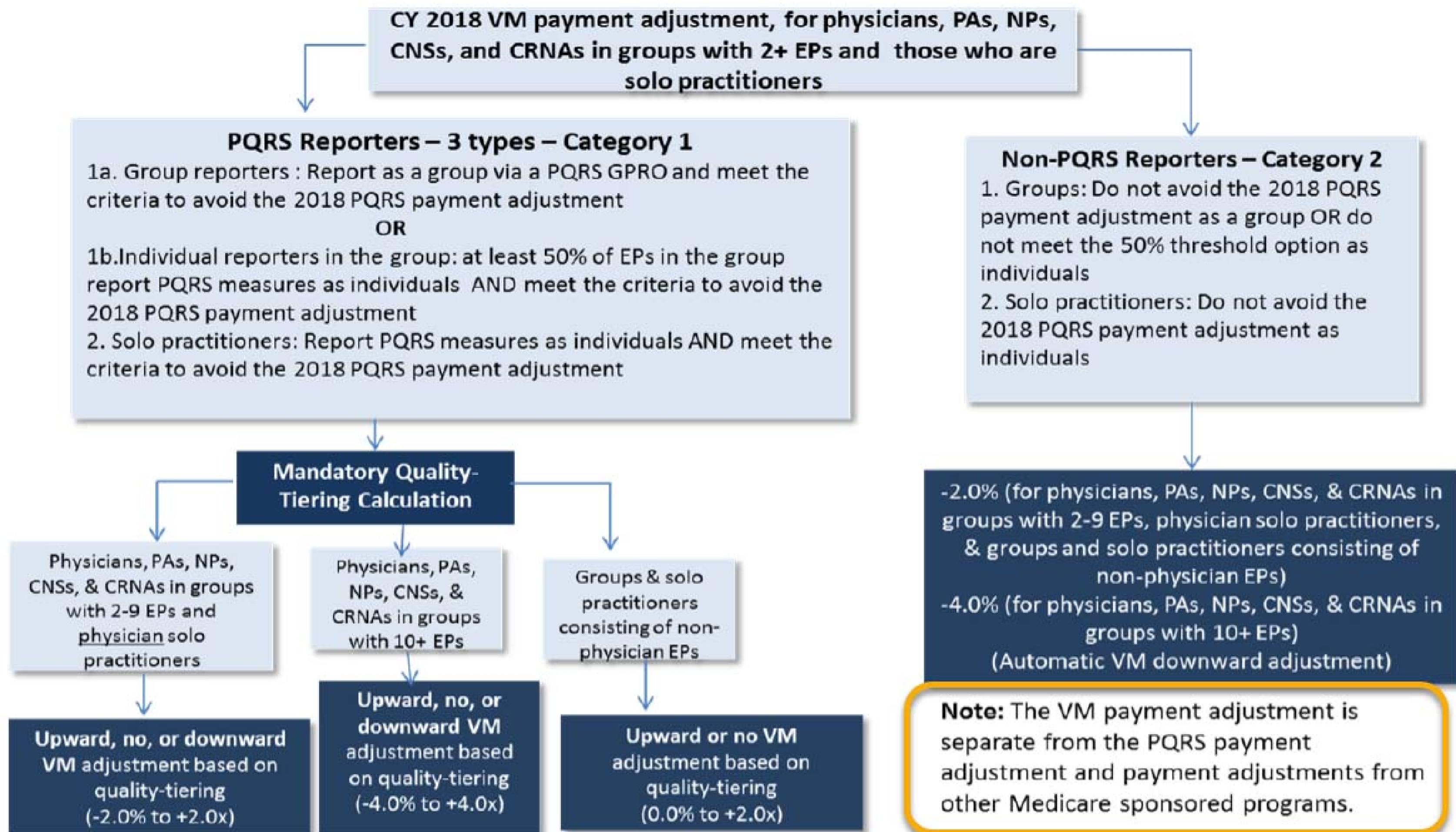
Measure Now, Penalize in 2 Yrs

- Current amalgam of programs
  - Meaningful Use
  - PQRS (Physician Quality Reporting System)
  - Value-Based Modifiers
- What was reported for 2016, is reported to providers in 2017 and effects payment in 2018

2016 Reporting Mechanisms

- Claims
- Qualified Registry (open until March 31)
- EHR Electronic Reporting (open until March 13)
- QCDR (open until March 31)

Easy to Understand CMS Explanation of Value Adjustments



MACRA

Medicare Access and CHIP Reauthorization Act

CMS's Latest Change

A New Generation of CMS Acronyms

- Just when you were getting used to:
  - MU (Meaningful Use)
  - PQRS (Physician Quality Reporting System)
  - VBM (Value-Based Modifier program)
- They've got a whole new set for you

What is it?

- Further evolution in physicians payment
- Eliminates the sustainable growth rate formula (SGR)
- Replaces MU, PQRS and VBM
- Continues Medicare trend towards shifting reimbursement away from FFS
- Applies only to “traditional” Medicare

MACRA Regulations

- Law passed at end of 2015
    - Like all these legal changes, a process of proposing regulations and then going through public hearing process before final regulations are adopted.
- First pass of regulations didn’t come out until late April ’16
- Law scheduled took affect Jan ’17, but final rules not released until mid-October ‘16

Who is Included?

- Physicians, PAs, NPs, CNSs, RNAs
- Bill more than $30,000 annually
- See more than 100 Medicare patients

Who is Excluded?

- New to Medicare in 2017
- Below volume threshold ($ or pts)
- Participating in Advanced Alternative Payment Models
- Additional limited exceptions for those in FQHCs, Rural Health Clinics or Critical Access Hospitals

Two Approaches

- Merit-Based Incentive Payments (MIPS)
  - Most doctors will use this track
  - Better for small physician groups
- Alternative Payment Models (APM)
  - More invasive changes to way care is provided
  - Requires lots of dedicated work to customize a plan

Should Everyone Panic?

- Regulations were released late, and originally called for reporting for entire year starting January 1st
- Practices needed more time to understand the rules and then make plans for gathering data and perhaps changing behavior
- Vendors didn't have time to make any necessary changes to support the reporting requirements (mostly using existing PQRS measures)

So CMS Slowed Things Down

- Relaxation of 2017 reporting requirements and penalties
- **2019 penalties can be completely avoided by simply testing the EHR and submitting test data, sometime during the year.**
- Report for part of the year (potential for tiny increase)
- Report for full-year (can potentially get a little bit more)

MIPS Track

- Replaces MU, PQRS and VBM
- Adds in Clinical Practice Improvement Activities (CPIA)
- Overall government spending for physicians (in total) will increase .5% 2017-2019, flat 2020-2022
  - Significant comfort that physicians can count on a predicable level of funding

MIPS Basics

- Reporting starts in 2017 and affects 2019 pay
- Use certified EHR
- Report in four areas
  - Quality *(similar to PQRS: 60% of total)*
  - Cost *(similar to VBM: 0% in 2017)*
  - Improvement Activities *(15%)*
  - Advanced Care Information *(similar to MU: 25%)*
- CMS grades your report card

MIPS Reimbursement

- Each doctor's report card is compared to peers – comparative grade affects 2019 FFS rates
  - If you are good, you get a bump in the fee-for-service rates compared to everyone else
  - If you minimally report, you are neutral
  - If you fail to report at all you will be penalized (4% in 2019.
  - "Pick Your Pace" in 2017

Pick Your Pace in 2017

- Dip your toe in the water
  - Submit any kind of data, just showing you are aware of the program
  - Eliminates possibility of 2019 reductions
  - Practices can get used to the program without worrying about repercussions
- Short-Term Reporting
  - Report for 90 day period
  - Potential for small payment adjustment
- Report for Full Year
  - Potential for modest positive adjustment

MIPS Reimbursement

- Variance starts at about 4% and grows to 9% by 2022.
- Additional bonuses can provide another 10% for “exceptional performance”
- Warning – not everyone can be exceptional (they are “grading” on a strict curve)
  - This means minimal bonuses in 2019
  - Greater variation starting in 2020

Important Take-Aways

- This really isn't a billing issue.
  - It affects what the payment level will be, but doesn't affect how we will do our job.
- Effects won't be seen until 2019, but will be based on 2017 performance
- Reimbursement is "budget neutral". Higher compensated doctors will only get this at the expense of those who are penalized

Alternative to MIPS is Alternative Payment Model

- Physician group proposes way of significantly reducing cost and improving outcomes and suggests new method for payment.
- Typically focused on a specific chronic condition or issue.
- Normally would include significant reworking of care model and adding or changing staff roles.
- Providers share risk and reward with Medicare that approach will save money

Simple Example
Reduce Inappropriate ER Visits

- Potential solution:
  - *Provide 24/7 access to care coordinator who would speak to patient considering going to ER (or intercepted at ER) and direct to urgent care or get immediately seen by PCP.*
- Implementation Difficulty: Easy.
- Potential benefit: Limited

More Complex Example
Reduce Care Cost for Diabetics

- Potential solution:
  - *Call patients three times a week to check on adherence to lifestyle protocols*
  - *Remotely monitor glucose levels through new technology*
  - *Intervene proactively as necessary*
  - *Provide classes by dieticians, ophthalmologists and podiatrists*
  - *Develop behavior modification group "therapy" sessions*
  - *Provide incentives for validated participation in exercise regimen*
- Implementation Difficulty: Hard.
- Potential benefit: High

Participating Providers Need To:

- Determine which clinicians would oversee program, develop the APMs and monitor progress
- Identify which patients in practice would be effected and how success would be measured and what data collection and reporting is appropriate
- Propose payment model to handle the specific patients

In the End

- Medicare analyzes costs and determines if program saved money
- Savings are shared between providers and Medicare
- Losses are shared between providers and Medicare, but providers losses are limited (to $400 per patient per year)

Conclusion

We need to continue to monitor these changes so we are aware of our responsibilities, and have a uniform “company line” when questioned by clients

We’ll developing handout materials generally describing MACRA and directing clients on where they can turn for more info

Know that this is less our problem than those who provider EMR systems