Washington Update
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Agenda
• Trending topics
• Medicare physician payment reform: MIPS & APMs
• 2018 proposed Medicare payment changes
• Political environment and healthcare reform
• Q&A
Non-Discrimination Standards

**What is it?** Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability by building on existing federal civil rights laws.

- Most notable changes impact provision of language assistance services to **limited English proficiency** individuals

**Who does it impact?** Most medical group practices (any practice that accepts federal financial assistance from any sources other than solely Medicare Part B, including Medicare Parts A or D, Medicaid, or Meaningful Use incentive payments)

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Section 1557

**How Do I Comply?**

- Formalize and document a language access plan (not required but suggested)
- Arrange for translation services
- Post a notice of nondiscrimination in English (can be combined with existing notices)
- Post “taglines” in the top 15 languages in your state in your physical office and significant publications and on website
- Practices with 15+ employees must designate compliance coordinator

**Sample Tagline**

**ATTENTION:** If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx). For more information, visit www.mgma.org/Section1557
CMS Narrows Scope of Claims Audits

Targeted Probe & Educate (TPE)

- TPE started as a pilot but is expanding to all MAC jurisdictions “later in 2017.”
- Selection of claims:
  - Items and services that pose the greatest financial risk or have the highest error rates
  - Focus on clinicians who have the highest claim error rates or have outlier billing practices

TPE at a Glance

- Up to 3 rounds, MACs will review 20-40 claims, per clinician, per round.
- Each round accompanied and followed by 1-on-1 education based on review results.
- Providers with continued high error rates after 3 rounds may be referred to CMS for additional action.

1 in 6 practices charged for EFT payments
MGMA advocacy

- MGMA to CMS: issue guidance prohibiting unreasonable EFT charges
- MGMA joins with other top industry voices to call for a stop to the abuse of "virtual" credit cards

Action steps for protecting your practice:
1. Request EFT payment using MGMA’s sample letter or by visiting CAQH’s EnrollHub
2. Stand firm against fees citing HIPAA regulations
3. Consider lodging a formal complaint with CMS

For more, access MGMA’s EFT/ERA Guide

Virtual Credit Card/EFT Service Fees

Typically released in Sept.

Why should you still care?
- Comparable metrics to MIPS
- Will impact 2018 Medicare payments
- If there are inaccuracies, informal review requests must be submitted by the deadline (typically late Nov. or early Dec.)

PQRS Feedback Reports & QRURs
Medicare Physician Payment Reform

*Mid-Year Status Report*

**MIPS Score**

1. ECs assigned final score of 0-100 points based on performance in 3 categories.
2. Final score compared to a performance threshold calculated/set by CMS each year.
3. Scores above threshold result in upward adjustment; score below threshold gets a penalty.

**Budget neutrality:** upward adjustment payout must equal penalty pool.
**Exception:** high performers receive additional incentive of up to 10% funded by $500 million each year until 2026.

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### MIPS “Pick your Pace” Options for 2017

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<th>Pick your pace</th>
<th>Definition</th>
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<tbody>
<tr>
<td>All-in</td>
<td>Report full MIPS data for at least 90 consecutive days (up to a full year)</td>
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| Report some data | Report 1 or more of the following for at least 90 consecutive days:  
- More than 1 quality measure  
- More than 1 improvement activity  
- More than 4 ACI “base” measures |
| Test the program | Report at least one of the following:  
- 1 quality measure; OR  
- 1 improvement activity; OR  
- 4 ACI “base” measures |
| Do nothing     | Report no data |

### Projected 2019 MIPS Payment Adjustments

- **MIPS Performance Threshold**
- **Exceptional Performance Threshold**
2017 MIPS Tips: Quality

- Benchmarks for same measure can vary by reporting mechanism
- Bonus points are awarded for all reported measures even if the measure not counted (up to the 10% cap)
- 3-point minimum, even if measures fail data completeness criteria
- Data completeness thresholds are based on the proportion of applicable patients, not the number of clinicians who report data

2017 MIPS Tips: Improvement Activities

- CMS will not be releasing more detailed activity-level specifications
- Criteria was purposefully kept broad to recognize ongoing efforts
- Supporting documentation is suggested for each activity
- Report via yes/no attestation in early 2018
- Only one clinician needs to attest to completing an activity for a group to count it
2017 MIPS Tips: Advancing Care Information

- Report base measures via yes/no attestation or one-patient denominator in early 2018
- Focus on health information exchange and patient access measures, which count as both base and performance measures
- Maximize bonus points for data you were already reporting in Meaningful Use (e.g., registry reporting)

MIPS Group Reporting

- Entire practice gets same MIPS score and payment adjustment
- Select 1 reporting mechanism per MIPS 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
2017 Advanced APMs

CMS estimates 10% of clinicians will participate in APMs in 2017

2017 APMs include:
- MSSP ACO Tracks 2 and 3
- Next Generation ACOs
- Comprehensive ESRD Care 2-sided risk model
- Comprehensive Primary Care Plus
- Oncology Care 2-sided risk model
- Comprehensive Care for Joint Replacement (CEHRT track)*

MIPS & APMs: group practice POV

**Positives**
- Stable FFS payment updates from which to launch MIPS and APMs
- Resets penalties (max -9% under PQRS, MU, VM)
- Leverages benefits of group practice model
- 90-day MIPS reporting options (versus full year)
  - IA category recognizes ongoing clinical improvement efforts

**Challenges**
- Lack of actionable feedback
- Overly complex MIPS scoring methodology
- No MIPS risk-adjustment in 2017
- Retains check-the-box measure reporting over clinical improvement
- Limited APM pathway
MGMA Resources

**Washington Connection (mgma.com/Washington)**
Weekly e-newsletter with breaking updates and everything you need to know from our nation's capital

**MACRA/QPP Resource Center (mgma.com/QPP)**
Your one-stop shop for new resources & information
- FAQs
- Participation checklist
- And more!

**Dedicated MIPS/APMs e-group**
Get your questions answered and engage in a dialogue with your MGMA peers about all things MACRA

Proposed 2018 Medicare physician payment changes
2018 MIPS & APMs proposed rule

<table>
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<th>Pros</th>
<th>Cons</th>
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| • Delays CEHRT mandate  
• Facility-based scoring option  
• Raises low-volume threshold  
• Includes new ACI exclusions  
• Delays counting cost | • Full-year quality reporting  
• Does not add a single Advanced APM  
• To avoid a penalty, practices and clinicians must earn 15 points; report 2 categories |

MGMA’s 2018 MIPS & APMs Advocacy Objectives

• Delay mandate to move to EHRs with new certification
• Continue “pick-your-pace” on-ramp to MIPS, including 90-day reporting option
• More timely feedback, i.e., quarterly reports
• Continue to reweight cost to zero while the agency implements key components, such as risk adjustment
• Take seriously recommendations of PTAC and adopt more AAPMs
2018 Physician Fee Schedule Proposed Rule

- Set a 2018 Medicare PFS CF of $35,9903
- Delay appropriate use criteria for advanced imaging services until 2019
- Retroactively lower PQRS reporting requirements
- Seek input about opportunities to reduce regulatory burdens on physician practices
- Reduce size & scope of Value Modifier penalties
- Solicit comments on reporting lab $$ data

MGMA’s 2018 PFS Advocacy Objectives

- Finalize the proposed delay in requiring appropriate use criteria consultation and documentation
- Hold medical groups harmless from 2018 penalties in the obsolete quality reporting programs if they reported some data in 2016
- Reduce unnecessary regulations and improve the quality and efficiency of healthcare delivery using the results of MGMA’s 2017 Regulatory Burdens survey as a compass
Next steps

- Read MGMA’s member-exclusive analysis of 2018 Medicare proposed PFS and MIPS and APMs rules.
- Final rules expected by early Nov.
- Stay tuned for MGMA’s analysis of both final rules.

Political environment and healthcare reform
Questions?