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WINTER 2018 NEWSLETTER

In November 2017 the Centers for Medicare & Medicaid Services (CMS) finalized two rules that impact Medicare payments in 2018. The Medicare Physician Fee Schedule (PFS) set 2018 rates. The Alternative Payment Models (APM) final rule made adjustments to the Merit-based Incentive Payment Systems (MIPS) criteria and addressed other policy changes. On February 9, 2018, the Bipartisan Budget Act of 2018 made still more changes. In this newsletter, we look back at the legislation that changed Medicare reimbursement, identify the most important changes for 2018 and suggest an approach to value based payment in your practice in the new year.

Margie Satinsky

2018 MEDICARE PAYMENT CHANGES – ARE YOU PREPARED?

A Look Back at the Context

With the passage of the Final Rule regarding implementation of key provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Medicare changed dramatically. Clinician payments for Part B services moved from a fee-for-service to a value-based payment system that combined the Medicare Meaningful Use (MU), Physician Quality Reporting system (PQRS) and Value-Based Modifier (VBM) systems into a single Quality Payment Program (QPP). The Final Rule offered two paths for participation. The first, the Merit-based Incentive Payment System (MIPS), was the one in which most Medicare providers who met eligibility criteria were expected to participate. The second path, the Advanced Alternative Payment Models (APM), offered both payment adjustments and an incentive payment for participating in the APM. The first performance year to which the changes applied was calendar year 2017. For those who submit data as required between January 2 and March 31, 2018, payment adjustments will occur in January 2019.

When CMS developed the new program, it expected to make changes over the course of the next few years. During 2017, the first performance year, both participants and advocacy organizations provided feedback to CMS that resulted in even more changes for 2018 than had been originally planned. Here are the highlights. For complete information, go to **cms.hhs.gov**. Address specific questions to **QPP@cms.hhs.gov** (866.288.8292).

What's New in 2018?

- **Changes in MIPS Scoring**

  Although MIPS retains the original four performance categories that contribute to the total amount of Medicare reimbursement, both the scoring and payment will change. Quality will now account for 50% of the final score (versus 60% in 2017). Cost/Resource Use, which was not taken into account in 2017, will account for 10%.

Two categories, Advancing Care Information and Clinical Practice Improvement, will retain their respective weights of 25% and 15%.

- **Changes in MIPS Medicare Payment Adjustments**
  As in 2017, changes in Medicare payments for eligible clinicians (ECs) depend on the option selected (i.e. MIPS or APM), on the time period for submission and on the quality results. Those who choose MIPS must earn at least 15 out of 100 points in 2018 to avoid a reduction of up to 5% in Medicare payment in 2020. Although this reduction is higher than the 3% penalty for performance year 2017, options for meeting the goal include: (1) satisfying the requirements of one MIPS category or (2) satisfying the requirements of subparts of multiple categories. Those who earn 70+ points can earn an additional bonus ranging from 0.5% to 10%. CMS will also recognize the special circumstances of two groups by offering an automatic five-point addition to the final MIPS score provided certain requirements are met. The groups are: (1) solo practitioners or groups of 15 or fewer ECs and (2) those who care for complex patients.
- **Recognition of Low Volume**
  CMS continues the exclusion of low volume practitioners, adjusting the threshold to further recognize the special circumstances of ECs and groups that provide care for relatively few Medicare patients. For 2018, those that bill $90,000 or less in Medicare Part B charges or that see 100 or fewer Medicare beneficiaries are exempt from the requirements for MIPS participation.
- **Increases in the Reporting Burden**
  To the consternation of many ECs and groups, the 2018 reporting requirements are potentially burdensome. Those who submit data for ACI and Clinical Practice Improvement Activities must submit data for a minimum of 90 days. Those who submit for the Quality category must submit 12 months of data. There's no reporting for the Cost category since CMS has the ability to use claims data for the calculations.
- **Certified EHR Technology (CEHRT) Requirements**
  For 2018, CMS will continue to specify requirements regarding certified EHR technology. The range of options offers flexibility and includes: (1) technology certified to the 2014 Edition; (2) 2015 Edition, or (3) combination of both Editions. ECs and groups that exclusively use the 2015 Edition CEHRT to report the five ACI base measures will receive a 10% bonus.
- **Requirements for Four MIPS Criteria**
  - **Quality:** CMS will require reporting on at least 60% of all applicable patient encounters for six measures that are submitted. Six measures have an upper limit of 7 points. ECs and groups that show improvement in this category between performance years 2017 and 2018 may earn up to an additional 10% on the Quality score.
  - **Cost/Resource Use:** In calculating the score using Part B claims information, CMS will use two measures that were included in the Value-Based Payment Modifier (VM). These are: (1) total cost of care for beneficiaries and (2) Medicare spending per beneficiary (includes both Medicare Part A and B payments

related to hospitalization). CMS will not release cost benchmarks in advance, as it plans to develop them using data that is submitted.

- **Advancing Care Information:** In 2018, ECs and groups will have new options for the e-prescribing and health information exchange measures. There are financial incentives for reporting to one or more public health agencies, clinical data registries or immunization registries. There's also a change for ECs who provide 75% of their services in an ambulatory surgical center. Finally, new hardship exemption categories include but are not limited to ECs and groups whose EHR has been decertified. The hardship application deadline remains at December 31 of the relevant performance year.
- **Clinical Practice Improvement:** For 2018, CMS has added activities that qualify for improvement. It has also created more demanding expectations for those group practices that seek full credit by qualifying as a patient-centered medical home (PCMH). The new requirements impact group practices with multiple sites.

- **New MIPS Exclusion for Clinicians Impacted by Hurricanes**

  Given the impact of three severe hurricanes, CMS will automatically apply a 2017 extreme and uncontrollable hardship exception to ECs located in the areas impacted by the storms as determined by the Federal Emergency Management Agency (FEMA).

- **Advanced APMs**

  Although the number of qualified participants in existing APMs is expected to increase, CMS has not finalized additional ones. Nonetheless, prior to 2019, it will develop a demonstration program to recognize participation in innovative alternative payment arrangements under Medicare Advantage as advanced APMs.

- **Changes under the Physician Fee Schedule (PFS) Final Rule**
  - As required by MACRA, the 2018 Medicare PFS conversion factor includes a 0.5% update. The calculation also reflects adjustments based on budget neutrality and the mis-valued code target recapture amount.
  - The Appropriate Use Criteria (AUC) program will not require eligible professionals to report until January 1, 2020.
  - CMS will retroactively lower reporting requirements for PQRS and Meaningful Use, two older quality performance measurement programs. It will also reduce the size and scope of 2018 penalties under the Value-Based Payment Modifier.

- **Bipartisan Budget Act of 2018 Modifications to MIPS:**
  - Medicare Part B drug costs are excluded from MIPS payment adjustments and low-volume threshold determination for MIPS participation.
  - Flexibility for scoring and weighting for the MIPS Cost category is more flexible for the next three years.
  - CMS has additional flexibility in setting performance thresholds for another three years.
  - There is clarification of the authority of the Physician Focused Payment Technical Advisory Committee's authority with respect to meaningful feedback on proposed alternative payment models.

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Your Approach Matters!

We strongly advise taking a practice-wide approach to value-based reimbursement. Begin by educating your organization about the changes for the 2018 performance year. If you have selected the MIPS option, estimate your MIPS score. Examine options for maximizing your Medicare reimbursement such as selecting alternative measures. Once you've decided on your approach, designate one individual to be responsible for the effort and share the information with your entire workforce. Success depends not only on what you count, but also on making sure you have the commitment and dedicated resources to make your strategy work. Good luck!

*For additional information, contact Margie Satinsky, President, Satinsky Consulting, at **919.383.5998** or **margie@satinskyconsulting.com**.*

Tune in for the NCMS Disaster Planning Webinar

Be sure and tune in for the North Carolina Medical Society's webinar *Planning Ahead: The Best Way to Address the Risk of Disaster* on Tuesday, March 20, 2018, 12:00 p.m.-1:00 p.m. Margie Satinsky will be the featured speaker. To register go to **https://register.gotowebinar.com/register/7943528796159049729**.

How Can Satinsky Consulting Help Your Practice?

For assistance with the following, please contact us at **919.383.5998** or **margie@satinskyconsulting.com**.

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- Managed Care Rate Negotiations and Contract Review
- Strategic Business Planning
- HIPAA Privacy and Security Rule Compliance and Training
- Disaster Planning
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