AQREVA
Medical Billing & Consulting

"When we are no longer able to change a situation -- we are challenged to change ourselves."
-- Victor E Frankl

Client Memo
November 2018

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What proposed 2019 MACRA changes mean for providers

A summary of the Quality Payment Program Year 3 Proposed Rule was provided in last month's newsletter. Sandra Greene discusses what these changes could mean for providers in her September 7, 2018, article for *Health Data Management.*

Since its introduction in 2015, MACRA, has focused on two main areas in healthcare: quality and cost. With the 2019 Medicare Physician Fee Schedule proposal, CMS is taking a major evolutionary step toward directly addressing the cost part of the patient care equation, Ms. Greene writes.

Five areas where the 2019 rule poses the most significant changes for hospitals and practices are listed below.

1. More emphasis on cost

In 2019, the cost performance category is scheduled to increase to 15 percent of the overall MIPS score, up from 10 percent in 2018. Going forward, the cost category could increase to as high as 30 percent by 2022.

2. Introduction of 'promoting interoperability'

Another proposal for 2019 is changing the name of the Advancing Care Information category to Promoting Interoperability, or PI, but the shift in this category is more than just a new title.

EHR systems must be 2015 CEHRT

Base scores will go away and be replaced by more stringent benchmarks for promoting interoperability.

Under the proposal, providers must bring their EHR systems up to 2015 Edition Certified Electronic Health Record Technology (CEHRT) standards. In addition, the "base score" concept would be removed, and more stringent benchmarks for what meets the CMS requirements for interoperability would make it more difficult to earn points under MIPS.

This change represents a complete overhaul of Meaningful Use, with some Stage 3 measures being eliminated and others being introduced for 2019.

3. Expanding who is qualified for reimbursement and who is exempt from reporting

The 2019 proposal also expands the low-volume threshold to exempt practices that deliver 200 or fewer covered professional services under the Physician Fee Schedule.

4. Reducing the length of reporting

After more than 50 provider groups petitioned CMS to cut the reporting period from a full calendar year to 90 days, the agency responded by including that change in the 2019 proposal.

90 Day Reporting Period for 2019

5. Addressing the opioid crisis

CMS is building on its existing requirements for electronic prescribing of controlled substances to address the ongoing opioid crisis. New for 2019, providers would be required to have a CEHRT that can query a patient's prescription history through a Prescription Drug Monitoring Program, and to incorporate an opioid treatment agreement between the patient and provider into the CEHRT.

Finding More Information

CMS has also created a Quality Payment Program website (https://qpp.cms.gov) providing detailed information about the changes from 2017 to 2018, and links to the 2019 proposed rule and resource library.

Maximizing MIPS Scores Through Chronic Disease Prevention – Jacqueline LaPointe, *RevCycle Intelligence,* October 17, 2018

Eligible clinicians can increase their MIPS scores and payment adjustments by reporting on relevant chronic disease prevention measures, the AMA found.

The healthcare industry is moving beyond a "sick care" system and shifting to chronic disease prevention to lower costs and improve quality. By tying payments to provider performance and patient outcomes, MIPS incentivizes providers to get ahead of expensive, adverse healthcare events like diabetes and heart disease.

Diabetes and heart disease are two of the most expensive and prevalent chronic diseases.

Preventing chronic diseases is a top priority for providers looking to improve care quality and lower costs. But preventing the conditions can also maximize provider reimbursement under MIPS, the AMA recently explained.

Preventing Diabetes Through MIPS

In its "Disease focus: Prediabetes" report, the AMA explains how clinicians eligible to participate in MIPS can maximize their performance score and prevent the spread of diabetes among their patients.

For example, if an eligible clinician is focusing on prediabetes and uses a 2015 Edition EHR system, then he or she can report on the patient-generated health data measure in the MIPS **Promoting Interoperability** performance category.

- To get credit for prediabetes work, the AMA suggests that eligible clinicians create a prediabetes risk test to score points for diabetes prevention efforts under Promoting Interoperability.

- The questionnaire should offer "patients the opportunity to learn about their risk for prediabetes while helping care teams identify patients at great risk."

Eligible clinicians can also maximize their MIPS scores while preventing diabetes through the **Improvement Activities** performance category.

- Chronic care and preventative care management is a key Improvement Activity for eligible clinicians, requiring clinicians to proactively manage chronic and preventative care for empaneled patients using one of more of the following:

  - Providing patients each year with the opportunity for development and/or adjustment of a personalized care plan.
  - Using pre-visit planning to improve preventative care and team management.

- Implementing reminders and alerts to educate patients about services needed and/or routine medication reconciliation.

- Other MIPS Improvement Activities related to prediabetes treatment include:

  - Glycemic screening services
  - Glycemic referring services
  - Practice improvements that engage community resources to support patient health goals
  - Participation in Maintenance of Certification (MOC) Part IV
  - Completion of the AMA STEPS Forward program
  - Implementation of condition specific chronic disease self-management support programs

The AMA noted that MIPS does not have relevant prediabetes measures in its Quality performance category.

Using Hypertension Prevention for MIPS Points

Eligible clinicians can earn points under MIPS for their hypertension prevention efforts using Quality measures, the AMA's "Disease focus: Hypertension" report shows.

For clinicians focusing on hypertension prevention in their practice, the AMA suggests that they report on the following Quality measures to increase their MIPS score:

1. Controlling high blood pressure (#236)
2. Hypertension screening and recommended follow up plan (#317)
3. Improvement in high blood pressure (#373)

Eligible clinicians can also report on the patient-generated health data and patient-specific education measures in the **Promoting Interoperability** performance category to have their hypertension prevention efforts count towards MIPS scores.

Additionally, MIPS offers **Improvement Activities** targeting hypertension prevention efforts:

- Providers who engage in hypertension prevention initiatives should report on the Chronic Care and Preventative Care Management for Empaneled Patients measure.
- Use of certified EHR to capture patient-reported outcomes
- Engagement of patients through implementation of improvements in the patient portal
- Use evidence-based decision aids to support shared decision-making
- Completion of the AMA STEPS Forward program

Preventative care is the name of the game in the current healthcare environment. Providers can align their preventative care efforts with their value-based reimbursement goals by focusing on MIPS measures relevant to their chronic disease prevention initiatives

Family Physicians to Test New Option for 10-Year MOC Exam

Physicians are hopeful that the pilot program could improve the learning experience and reduce burden, writes Shannon Firth in her October 9, 2018, article for *MedPage Today.*

A new, more flexible alternative to the current 10-year "high stakes" MOC exam will soon be available to family physicians, announced the American Board of Family Medicine (ABFM) at its 2018 Congress of Delegates meeting.

Jerry Kruse, MD, chair of the ABFM, anticipates the program, which will use a longitudinal assessment, will be available to test-takers in January 2019.

He noted that the traditional 10-year exam will remain an option for those who choose it.

Medpagetoday.com

Under the new pilot program, participants receive approximately 25 questions every 3 months. They can be answered on any computer or tablet at any time over a period of 3 to 4 years.

For those who participate, once the exam is completed, the participants will not need to take another test until 2029, Dr. Kruse stressed.

The test will be open-book, clinical references may be used, and participants will be given 5 minutes to respond to each question.

Also, no additional payment, beyond the current standard fee will be required, Dr. Kruse said.

Another benefit of the pilot is that participants will be able to learn immediately whether a question is correct or not, along with references on the topic.

The ABFM is also committed to a new approach for engaging with physicians focused on "two-way" and "just-in-time" communication. AAFP members seemed open to the alternative testing strategy.

Throughout the process, the ABFM will solicit feedback about how to improve the assessment.

Get Need-to-Know Facts on Ordering Durable Medical Equipment – AAFP.org

Medicare Administrative Contractors Offer New Resources

The hassles associated with prescribing and ordering durable medical equipment (DME) for patients has long been a serious source of frustration for physicians.

The rules and restrictions when ordering DME for Medicare patients are particularly cumbersome.

To help ease the strain on already overburdened practices, CMS Medicare administrative contractors recently created new online resources for physicians to ensure they have all the necessary documentation in place.

Included in the recently added materials are easy-to-use checklists tailored to specific DME products that physicians often prescribe for their patients, such as nebulizers, canes and crutches, and glucose monitors and related supplies.

Getting the appropriate documentation completed correctly the first time will help reduce the administrative burden association with DME prescribing, thereby saving physicians time and money.

This important resource webpage, with a bevy of other items that should interest family physicians, was last updated on Sept. 25th.

The webpage can be found at: med.noridianmedicare.com

Telehealth Expansion for Medicare Advantage Plans

As part of the Bipartisan Budget Act of 2018 issued on October 26, 2018, CMS is proposing to eliminate geographical restrictions on telehealth access in Medicare Advantage plans by 2020. The proposal would also give members more locations to access care, including their own home, reports Eric Wicklundh in his October 29, 2018, article for *mHealth Intelligence*.

"The proposed rule would give MA plans more flexibility to offer telehealth benefits to all their enrollees, whether they live in rural or urban areas," the agency stated. "It would also allow greater ability for Medicare Advantage enrollees to receive telehealth from places including their homes, rather than requiring them to go to a health care facility to receive telehealth services. Plans would also have greater flexibility to offer clinically-appropriate telehealth benefits that are not otherwise available to Medicare beneficiaries." CMS wrote in its announcement.

In the October 26th issue for *Skilled Nursing News*, Alex Spanko's article "CMS Moves to Expand Telehealth Coverage Under Medicare Advantage," explains how the proposal could impact skilled nursing facilities and providers.

Under traditional Medicare, telehealth services are only covered for rural residents, who may need to travel considerable distances to receive in-person care. Mordy Eisenberg, chief operating officer of Tapestry Telehealth, told *Skilled Nursing News* earlier this year that only about a third of the nation's more than 15,000 nursing homes qualify as rural.

Virtual doctor visits, however, have been increasingly touted as a way to reduce rehospitalizations and ease financial strains on both long-term health care providers and other operators along the spectrum, reports Mr. Spanko.

A single remote doctor can see residents at multiple care facilities, making 'virtual rounds.'

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A single remote doctor can see residents at multiple care facilities, for instance, making "virtual rounds" that help nurses and other frontline staff catch medical issues and resolve them before they escalate to the level of hospitalization.

VA to Cease Current Community Care Overpayment Recovery Audit

As required by federal law, in 2016 VA awarded a contract to perform an audit of community care payments to identify potential overpayments and recover funds. The audit, much like recovery audit contracts with Medicare or commercial insurances, is a review of claims and supporting medical documentation.

VA subsequently became aware that certain claims were not being processed in accordance with VA's payment regulations, resulting in overpayments; these claims were included in the recovery audit contract.

After listening to concerns raised by providers and evaluating VA's internal processes and federal financial requirements, VA has decided that the current audit will cease. As a result, VA is temporarily suspending debt collections for Community Care payments through a third-party auditor while pursuing additional approaches that will take into account individual community provider circumstances and alternative payment options while also ensuring proper stewardship of public funds.

SNF Quality Reporting Program Data on Nursing Home Compare

The inaugural release of the SNF Quality Reporting Program (QRP) data on the Nursing Home Compare website occurred on October 24, 2018.

Why is this information being released?

In accordance with Section 1899B(g)(1) of the Social Security Act, which requires CMS to provide for the public reporting of SNF provider performance on the quality measures, CMS announced the inaugural release of the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) quality data on Nursing Home (NH) Compare.

Why is the SNF QRP data being posted on Nursing Home Compare?

Nursing Home Compare allows you to find and compare SNFs that are certified by Medicare and nursing facilities that are certified by Medicaid collectively referred to as nursing homes.

This website contains quality of resident care and staffing information for more than 15,000 nursing homes around the country, and will now include SNF quality data that can be used to help compare SNF providers by their performance on important indicators of quality, such as the percentage of SNF's residents that develop pressure ulcers, or how many residents fall and are injured as a result of the fall.

The site will show how a SNF's performance on quality measures compares to that of other SNFs, as well as to the national average. Data can showcase a SNF's ongoing commitment to quality, improving engagement and confidence among staff, residents, caregivers, families, and stakeholders.

What are the SNF QRP quality measures that have been added to Nursing Home Compare?

CMS has added the following five SNF QRP measures to Nursing Home Compare:

Assessment-based measures:

1. Percentage of Residents or Patients in a SNF that develop new or worsened pressure ulcers;
2. Percentage of residents or patients whose activities of daily living and thinking skills were assessed and related goals were included in their treatment plan;
3. Percentage of SNF patients who experience one or more falls with major injury during their SNF stay.

Claims-based measures:

1. Medicare Spending Per Beneficiary (MSPB) for patients in SNFs; and
2. Rate of successful return to home or community from an SNF.

SNF Provider Preview Reports- Now Available

Skilled Nursing Facility Provider Preview Reports have been updated and are now available. Providers have until November 30, 2018 to review their performance data on quality measures based on Quarter 2 -2017 to Quarter 1 - 2018 data, prior to the January 2019 Nursing Home Compare site refresh, during which this data will be publicly displayed.

Corrections to the underlying data will not be permitted during this time. However, providers can request a CMS review during the preview period if they believe their data scores displayed are inaccurate.

For More Information please visit the CMS SNF Quality Public Reporting webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Public-Reporting.html

CMS Takes Action to Modernize Medicare Home Health – CMS Press Release

On October 31, CMS finalized significant changes to the Home Health Prospective Payment System to strengthen and modernize Medicare.

Specifically, CMS made changes to 1) improve access to solutions via remote patient monitoring technology; 2) updated payments for home health care with a new case-mix system: 3) begin the new home infusion therapy benefit; and 4) reduce burden.

New home infusion therapy services will reduce unnecessary reporting measures for certifying physicians. This will result in annual cost savings and provide Home Health Agencies (HHAs) and doctors what they need to give patients a personalized treatment plan that will result in better health outcomes.

Beginning with CY 2020, CMS is implementing changes required by law, including a new case-mix system called the Patient-Driven Groupings Model (PDGM) that puts the focus on patient needs rather than volume of care. The PDGM relies more heavily on patient characteristics to more accurately pay for home health services.

CMS is promoting innovation and modernization of home health care by allowing the cost of remote patient monitoring to be reported by home health agencies as allowable costs on the Medicare cost report form. This is expected to help foster the adoption of emerging technologies by home health agencies and result in more effective care planning, as data is shared among patients, their caregivers and their providers.

This final rule implements temporary transitional payments for home infusion therapy services for CYs 2019 and 2020, as required by the Bipartisan Budget Act of 2018, until the new permanent home infusion therapy services benefit begins on January 1, 2021.

CMS is also eliminating the requirement that the certifying physician estimate how much longer home health services are needed when recertifying the need for continued home health care.

Changes in data collection under the new case-mix system, coupled with the removal of seven Home Health Quality reporting measures will reduce burden for HHAs by approximately $60 million annually, beginning in CY 2020.

Medicare News

Obtain an EIDM Account

The MIPS 2018 performance year ends on December 31, 2018. To access the Quality Payment Program Portal and submit your 2018 performance data, you'll need your EIDM User ID and Password. If you do not have an EIDM account, navigate to the CMS Enterprise Portal and select 'New User Registration' to create one: https://portal.cms.gov

Once you complete your EIDM account registration you will receive an e-mail acknowledging your successful account creation with your EIDM User ID. Use your unique EIDM User ID and Password to login to the Quality Payment Program Portal.

More information can be obtained by visiting the Quality Payment Program Website: https://qpp.cms.gov

MIPS Exception Applications – Applications due December 31, 2018.

CMS provides the opportunity for MIPS-eligible clinicians to apply for exceptions for MIPS (all performance categories) or the Promoting Interoperability performance category if they don't meet the minimum threshold exclusion.

In order to be exempt from all performance categories of MIPS, MIPS eligible clinicians must quality for the **EXTREME AND UNCONTROLLABLE CIRCUMSTANCES** exception:

- "Extreme and uncontrollable circumstances" are defined as rare events (highly unlikely to occur in a given year) entirely outside the clinicians control and the facility in which they practice.
- MIPS-eligible clinicians must submit a request for reweighting of the Quality, Cost, and Improvement Activities performance categories

The **Promoting Interoperability Hardship Exception** only applies to the Promoting Operability category of MIPS. Lacking certified electronic health record technology (CEHRT) does not qualify the MIPS-eligible clinician or group for reweighting of the Promoting Interoperability performance category.
Eligible clinicians will need to select from one of the following reasons in order to qualify for the hardship exception:

- MIPS-eligible clinicians in small practices
- MIPS-eligible clinicians using decertified EHR technology
- Insufficient Internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT

Clinicians who qualify for the exception will have their Promoting Interoperability performance score reweighted from 25% to 0%, with the 25% reallocated to the Quality performance category. ***Providers must still attest to the other three performance categories: Quality, Cost, and Improvement Activities.***

MIPS-eligible clinicians that are considered Special Status (i.e. hospital-based clinicians, NP's, PA's, non-patient facing, etc) will be automatically reweighted and will not need to submit a Quality Payment Program Exception Application. Applications can be completed on the Quality Payment Program website: https://qpp.cms.gov

Medicare Deductibles, Premiums for 2019

CMS has announced that Medicare Part A and Part B premiums and deductibles are expected to increase slightly for the 2019 plan year. Part B members will see small increases in both their premiums and their deductibles, while Part A beneficiaries will only see an increase in deductibles.

CMS estimates the average monthly Part B premium may increase by $1.50 from $134 in 2018 to $135.50 in 2019. Part B deductibles are only increasing by two dollars, from $184 in 2018 to $186 in 2019. Part A deductibles are estimated to increase from $1340 in 2018 to $1364 in 2019.

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