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"Pearls don't lie on the seashore. If you want one, you must dive for it." -- Chinese proverb

Client Memo
July 2019

NEWS Update

Reducing Health IT Utilization In MIPS

The AMA, AAFP, and other medical associations advocated for lawmakers to simplify MACRA and eliminate MIPS health IT utilization measures, reported Kate Monica, in the May 8, 2019 article for *EHR Intelligence*.

In testimony before the Senate Committee on Finance, the AMA, AAFP, and AMGA voiced their support for the shift to value-based care and MIPS, but urged policymakers to simplify the program by eliminating some health IT utilization measures and instead focusing on outcome-based measures.

In written testimony, AMA President Barbara McAneny, MD, applauded CMS for making efforts to ensure small practices can participate in MIPS: "the AMA appreciates the accommodations for small practices that are included in MIPS. In 2018, physicians with annual Medicare allowed charges of $90,000 or less or 200 or fewer Medicare patients were exempt from the QPP altogether."

The AMA has also supported reduced reporting requirements for small practices, hardship exemptions from the Promoting Interoperability MIPS performance category for qualifying small practices, bonus points for small practices, and technical assistance grants to help small and rural practices succeed in the program.

While these policies make reporting requirements easier on small and rural practices, the AMA is still concerned about certain policies that inhibit these providers from succeeding in the program.

"Given the lower scores achieved by small and rural practices compared to all MIPS eligible clinicians, the AMA urges Congress and CMS to continue to implement policies that help small and rural physician practices succeed in MIPS," Dr. McAneny added.

For example, Congress and CMS can make MIPS more cohesive and meaningful to physicians and patients by allowing physicians to focus their participation around a specific procedure, condition, or public health priority.

The AMA also recommended Congress update the Promoting Interoperability (PI) performance category to allow physicians to use certified EHR technology (CEHRT) in more clinically relevant ways and develop a separate threshold for small and rural practices to ensure all physicians participating in MIPS do so on an even playing field.

The association also recommended policymakers incentivize reporting on new quality measures, especially those geared toward specialties.

For its part, AAFP recommended lawmakers reduce the scoring complexity within MIPS.

"The implementation of MIPS has created a burdensome and extremely complex program," stated AAFP President John Cullen, MD.

Cullen testified that MIPS cost category measures are flawed and overly strict on primary care physicians compared to clinicians in other sub-specialties. "We urge Congress to extend CMS's authority to weigh the MIPS cost category below 30% to allow time to overhaul existing measures," said Cullen.

AAFP members also expressed concern over the PI performance category within MIPS.

"CMS is hamstrung in PI since the agency is bound to Meaningful Use requirements by legislation, including both the American Recovery and Reinvestment Act and the Affordable Care Act," stated Cullen. "The AAFP calls on Congress to repeal Meaningful Use requirements and allow HHS to remove these requirements from the PI category."

Specifically, AAFP takes issue with the "all or nothing" nature of the category, Cullen testified. He also recommended CMS eliminate health IT utilization measures, as well as any required measures. Instead, Cullen suggested

clinicians be given the flexibility to choose measures relevant to their practice.

"All measures within the promoting interoperability category should be attestation-based," Cullen added.

AMGA Director Scott Hines, MD, stated his support for Congress's goals in implementing MIPS but noted that CMS has excluded nearly half of the eligible clinicians from MIPS requirements.

By excluding half of providers from MIPS, the system has devolved into an expensive regulatory compliance exercise with little impact on quality or cost," Hines added.

To improve reimbursement rates, Hines recommended Congress no longer exclude providers from participating in MIPS.

With these recommended changes, medical associations hope to push the healthcare industry further toward its goal of realizing a value-based care system.

MIPS Data Validation and Audit Begin June 2019 for Performance Years 2017 and 2018

CMS has contracted with Guidehouse to conduct data validation and audits of a select number of MIPS eligible clinicians. MIPS eligible clinicians, groups and virtual groups are required by regulation to comply with data sharing requests, providing all data as requested by CMS.

If you are selected for data validation and/or audit, you will receive a request for information from Guidehouse. It will be sent via email or by certified mail. **Please be on the lookout for this notification. You will have 45 calendar days from the date of the notice to provide the requested information.**

Please note, if you do not provide the requested information CMS may take further action, to include the possibility that you will be selected for future audits. To help avoid this, CMS is in the process of developing resources to support clinicians selected to participate.

CMS provides data validation and audit resources which are available in the Quality Payment Program Resource Library:

For more information please go to the Resource Library on the Quality Payment Program website: https://qpp.cms.gov

QPP Submissions No Longer Support XML Format

As a reminder, QPP Submissions will no longer support QPP XML format starting January 2, 2020. The QPP Submissions API will only accept requests and return responses in QPP JSON format. This means that files must be uploaded to the QPP website in either QPP JSON or QRDA III XML.

Please check with your EHR vendor or MIPS registry to make sure they will be in compliance.

Promoting Interoperability Objectives for MIPS 2019

The Promoting Interoperability category of MIPS focuses on five basic objectives for 2019. This category is necessary to ensure that patients are being given access to high-quality care and better health outcomes.

There are eleven (11) measures spread across five (5) objectives to report:

The five main objectives are:

1. E-Prescribing
   a) e-Prescribing
   a) Query of PDMP
   b) Verify opioid treatment agreement
2. Health Information Exchange
   a) Support electronic referrals by sending health information
   b) Support electronic referrals by receiving and incorporating health information
3. Provider to Patient Exchange – provide patients access to their health information
4. Public Health and Clinical Data Exchange (exclusions may be claimed for these measures)
   a) Syndromic Surveillance Reporting
   b) Public Health Registry Reporting
   c) Immunization Registry Reporting
   d) Electronic Case Reporting
5. Complete a Security Risk Analysis -- still required for the calendar year in which the performance period occurs but **is an unscored measure.**

Physician Partnership Agreements

When was the last time you reviewed your partnership agreement? Even if you aren't looking for shareholders or partners, if you haven't looked at your agreement recently, now is the time, advises Suzanne Madden, in the May 25, 2019, issue of *Medical Economics.*

Market forces have changed significantly over the last several years, and the partnership agreement you signed in the past may not cover issues like reduced responsibilities to accommodate work-life balance, retiring partners, or how to manage value- or performance-based contracting in which one partner's performance can determine if the group receives any performance payments at all.

Here are some of the key questions that you should consider in every partnership agreement.

Addition of Partners: Does the current agreement outline how you will add new partners or shareholders? Is there a buy-in? If so, will that be in the form of financial or sweat equity? Has a method been determined for assessing that value and has it been incorporated into the agreement?

Division of Duties: Will all partners carry equal responsibility and be expected to dedicate equal time to administrative and clinical duties? Or is there one 'managing partner,' or even a Board of Directors? If so, how are those partners compensated differently?

Reductions in Responsibility: How will you address one partner stepping back from their obligations for reasons such as health or family issues or upcoming retirement? Are there terms clearly defined to accommodate that, either in the form of reduced compensation or even the ability to maintain partnership status?

General Compensation: How will profits be shared? Will they be distributed equally or will there be a productivity component involved? What model will you use to determine that?

Performance-based Pay: More and more often, we see payer contracts that have 'value- or performance-based' components attached to compensation. How will these group-based payments be distributed? Are there penalties for individuals that fail to meet targets, since that could put substantial sums at risk for the group as a whole?

Individual Risk: Is each partner responsible for their coding and documentation? In the event of an insurance audit that results in take backs, is the group liable for an individual's errors?

Dispute resolution: How will disputes be resolved? For example, if one partner wants to expand or invest but the other does not, how will that be decided? What happens if you simply can't get along with a partner any longer—do you have the right to force them out? If so, is there a premium allocation to be paid to that partner in the event of this situation?

Withdrawal from Partnership: Does the agreement designate how far in advance a partner wishing to leave the group must notify the other members? For example, retirement notices should be given at least 18-36 months ahead of time, and it may be prudent to consider that shorter notification periods could result in forfeiture of part of the buyout.

Addressing your agreements from these angles will not only help you cover your bases in the event of unforeseen circumstances, it also ensures that you are providing the best ongoing governance of your practice for many years to come.

Physician Compensation Grew in 2018

A new report on physician compensation found primary care and specialty physicians, as well as non-physician providers, saw pay increases from 2017 to 2018, reports Jacqueline LaPointe in the June 5, 2019, issue of *RevCycle Intelligence.*

The average physician compensation for primary care and other medical specialties increased by 3.4 percent and 4.4 percent from 2017 to 2018. The findings are from MGMA's annual *Provider Compensation and Production Report*, which examines data from more than 147,000 physicians, Ms. LaPointe writes.

In addition to immediate physician compensation growth, this year's report also found that the annual pay for advanced practice providers increased by 2.9 percent in 2018 compared to the previous year.

-- Physician News.com

Total compensation among all providers has grown at a rate of seven to 11 per-cent over the last five years.

Demand for providers is dramatically rising due to the physician shortage. The healthcare industry will be short of up to 121,900 physicians by 2032, the Association of Amer-

ican Medical Colleges recently reported in an updated analysis of healthcare's physician shortage problem.

As a result, healthcare organizations are increasing compensation rates and offering competitive benefits to attract physicians from the shrinking physician pool, reported MGMA.

Compensation for non-physician providers also significantly increased during the period.

Physician assistants saw a 10.35 percent boost from 2017 to 2018 and at the same time, nurse practitioners received a four percent increase. Physician assistants, nurse practitioners, and non-physician providers are stepping in to ensure patients receive care despite the physician shortage.

Providers across the board are seeing sizable increases in total compensation, the research shows. And they are likely to continue realizing significant pay increases and more competitive benefits as healthcare organizations explore strategies to attract and retain high-quality providers during the physician shortage.

New Long-Term Care Law Could Lead to a Home Care Business Boom

A new law designed to help fund long-term care services could mean big business for home care providers down the road writes Joyce Famakinwa in *Home Health Care News*, May 19, 2019.

On May 13, 2019, Washington Governor Jay Inslee officially signed the Long-Term Care Trust Act into law. The groundbreaking tax could be the first of several of its kind to sweep the nation.

Experts believe the Long-Term Care Trust Act will be particularly impactful on home care agencies compared to other post-acute service providers.

The law requires state residents to pay into a long-term care program through an employee payroll tax starting no later than January 2022. Eligible individuals would then have access to up to $36,500 in financial support for things like in-home care, meal deliveries and home modifications.

To be eligible under the law, recipients would need assistance with at least three activities of daily living (ADLs), in addition to meeting several other requirements.

Washngton is the first state to pass this kind of long-term care support law, though rising health care costs may trigger other states to follow suit.

The new law has likewise been lauded by LeadingAge, one of the largest aging services advocacy organizations in the country.

Already, states like Michigan and Illinois are looking to create similar long-term care financing models, while California is considering a ballot initiative on a public long-term care financing program, according to experts.

In many ways, the home care industry is at a tipping point, with more and more states recognizing the inherent value providers bring to the table — not only related to aging in place, but also when it comes to reducing hospital readmissions and avoiding trips to the emergency room.

Until more policies catch on, the Washington measure is a step in the right direction, especially because it also requires potential home care providers to be licensed by the state.

The payroll tax would be 0.58% on Washington employees' earnings. Based on the per capita average income in Washington of about $37,000, the average monthly contribution would be about $18 per person.

What Chronic Care Patients Need To Get Better – Staff, *Medical Economics*, May 25, 2019

Patients with chronic conditions such as diabetes, COPD, and congestive heart failure are some of the most challenging for physicians to treat.

The good news is that there are proven strategies for physicians to help patients improve their management of these difficult conditions, said Edward Wagner, MD, MPH, an internist and director emeritus for MacColl Center for Healthcare Innovation, Kaiser Permanente Washington Health Research Institute, Seattle, Washington.

Dr. Wagner said that there are key functions that practices must provide to patients to better manage chronic conditions. These include:

Population management: Staff uses data to identify and close care gaps by reaching out to patients with conditions judged by performance metrics.

Planned care: A planned visit is an encounter that uses patient data, team and practice organization, and decision support to ensure that patients receive the care they need.

Self-management support: Since managing chronic conditions often requires patients to change daily habits, practices must work with patients to create plans and help

link them to services such as health coaches, nutritionists and more. Setting goals and documenting progress is key, Wagner added.

Medication management: the goal of this function is to treat using protocol-based prescribing and monitoring of adherence and outcomes. Medication reconciliation is viewed as a critical intervention and the process begins with a medical assistant reviewing meds before every visit. Pharmacists also have a role to play, Wagner said.

Referral management: Staff provides assistance and support to link patients to the specialists and community services they need to adhere to their treatment plans.

Care management and follow-ups: Staff stays in regular contact with patients between visits in order to address their concerns and questions. Patients with greater care needs may require more intensive monitoring.

Behavioral management: Primary care and a behavioral health team must form an "integrated care team" and share accountability for the whole health of patients with behavioral health issues such as chronic depression, addiction and other conditions.

Connected Care: The Chronic Care Management Resource – CMS.gov website

An estimated 117 million adults have one or more chronic health conditions, and one in four adults have two or more chronic health conditions. Through the Connected Care campaign, the CMS Office of Minority Health and the Federal Office of Rural Health Policy at the Health Resources & Services Administration will raise awareness of the benefits of CCM for patients with multiple chronic conditions and provide health care professionals with resources to implement CCM.

The Connected Care initiative provides resources and tools that can help health care professionals learn how to implement chronic care management (CCM) and receive payment for providing these services.

Chronic care management is care coordination services done outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

These services are typically non-face-to-face and allow eligible practitioners to bill for at least 20 minutes or more of care coordination services per month.

Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- Schedule for periodic review and, when applicable, revision of the care plan

A Chronic Care Management Connected Care Toolkit is available to help providers deliver the coordinated care patients need and deserve.

The toolkit can be downloaded from:
https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CCM-Toolkit-Updated-Combined-508.pdf

United Healthcare News

Preventive Screening Guidelines for Medicare Advantage Plans for 2019

Medicare does not pay for the physical; however, as a Medicare Advantage plan, United's AARP and OptumCare do. United Healthcare will pay for both: one G code and one Routine exam each year. They do not have to be 12 months apart.

United Healthcare also offers their members a benefit of a home visit for the AWV. If that should occur, OptumCare will also pay the PCP should both be done.

Things to keep in mind:

- Annual Routine Physical Exam coverage: If you bill the 99XXX codes for these services, you must provide a head-to-toe exam **and can't bill for a separate breast and pelvic exam, digital rectal exam, or counseling to promote healthy behavior**.

- Members may receive either the Welcome to Medicare Visit or the Annual Wellness Visit along with the Annual Routine Physical Exam on the same day from the same PCP. Please **don't submit either of these two visits with a -25 modifier**.

- When performing a separately identifiable medically necessary E/M service in addition to the IPPE, providers may also bill 99201-15, reported with modifier 25. When medically indicated, this additional E/M service is subject to the applicable copayment for an office visit. Any additional services provided are subject to applicable cost-sharing.

The following services are included in the $0 copayment for wellness visits:

G0402 Welcome to Medicare Visit
G0438 Annual Wellness Visit Initial
G0439 Annual Wellness Visit Subsequent
99385-99387 Annual Routine Physical New Patient
99395-99397 Annual Routine Physical Established Patient

If you also bill other services with the visit, and those services are normally subject to a copayment or co-insurance, that copayment or co-insurance applies even if the primary reason for the visit was for a wellness exam.

Advanced Care Planning - $0 in-network when billed with the wellness visit and a 33 modifier; otherwise, cost-sharing may apply.

EKG Screening – Subject to member cost-sharing in most plans.

UnitedHealthcare Preferred Lab Network Launches July 1, 2019

The following labs were selected to be part of United Healthcare's Preferred Lab Network, effective July 1, 2019:

- AmeriPath Inc.
- BioReference Laboratories, Inc.
- GeneDX
- Invitae Corporation
- LabCorp
- Mayo Clinic Laboratories
- Quest Diagnostics

Out-of-Network Lab Approval Required

Out-of-network laboratory referrals can create excess costs in the health care system and may pose a potential quality risk to your patients. To help protect their patients, providers are required to refer lab services to a participating lab provider.

For an exception to this requirement, providers must have both:

1. Written consent from the member to use an out-of-network laboratory for that member's lab service for that date of service. The consent indicates the member has discussed the option to use an in-network lab with their care provider and they have made an informed decision to receive services from an out-of-network laboratory despite the potential increased out-of-pocket costs associated with that decision.

2. UnitedHealthcare approval to refer the member to an out-of-network laboratory for that member's lab service for that date of service.

Beginning Aug. 1, 2019, UnitedHealthcare will require an online process to satisfy the exception requirements outlined above, prior to referring members with UnitedHealthcare commercial benefit plans to out-of-network laboratories for testing services.

To find in-network laboratories, please visit: UHCprovider.com/findprovider > Search for a Provider > Medical Directory > choose the member's health plan and state > Places > Labs and Imaging > Lab Locations.

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