AQREVA
Medical Billing & Consulting

Client Memo
September 2019

"Hard work keeps the wrinkles out of the mind and spirit."
-- Helena Rubinstein

NEWS Update

Quality Payment Program for 2020

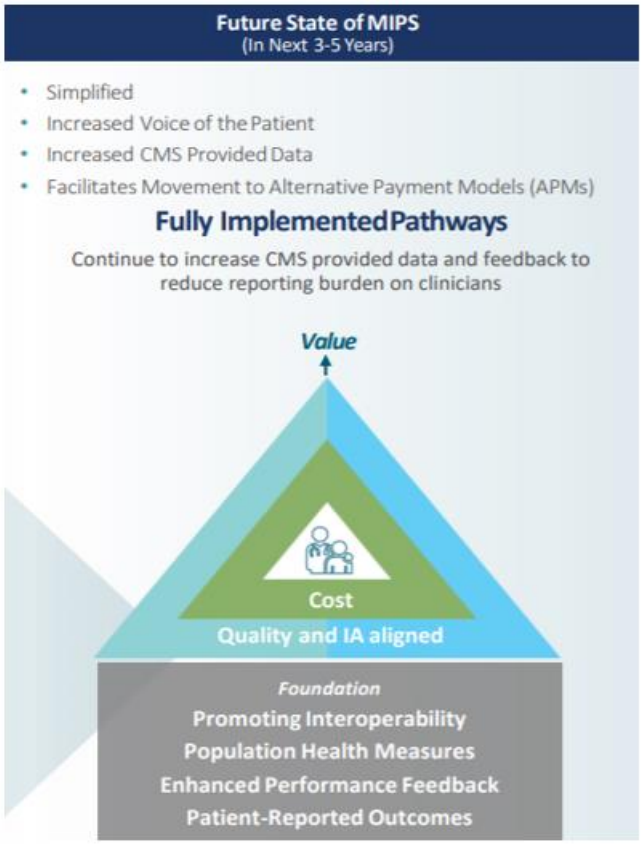
On August 13, 2019 CMS released its Quality Payment Program Proposed Rule for 2020.

Each year, CMS has made incremental changes to the program but additional improvements are needed to reach the goal of developing a meaningful program for every provider.

CMS is now proposing MIPS Value Pathways (MVPs) to create a new participation framework beginning with the 2021 performance year. Eligible clinicians are to be transitioned to the new MVP framework over the next two years, with 2020 being a transitional year.

This new framework would:

- Unite and connect measures and activities across Quality, Cost, Promoting Interoperability, and Improvement Activities categories.
- Incorporate a set of administrative claims-based quality measures that focus on population health/ public health priorities.
- Streamline MIPS reporting by limiting the number of required specialty/condition specific measures.
- Clinicians would then report on measures across the Quality, Cost, and Improvement Activities categories based on their specialty or the condition being treated.



MIPS for 2020

Eligibility: No proposed changes to the MIPS eligible clinician types.

Low Volume Threshold: No proposed changes to low-volume threshold criteria.

Opt-In Policy: No proposed changes to opt-in policy for providers excluded from MIPS based on low-volume thresholds.

MIPS Determination Period: CMS will look at your Medicare claims from two 12-month segments aligned to the fiscal year.

- First 12-month segment: October 1, 2018 – September 30, 2019
- Second 12-month segment: October 1, 2019 – September 30, 2020
- During the MIPS determination period, CMS will also identify MIPS eligible providers with the following special status: Non-patient facing; small practice; hospital-based; and ASC-based.

MIPS eligible clinicians with a special status are included in MIPS and qualify for special rules.

Having a special status does not exempt a clinician from MIPS.

New weights proposed for 2020 are as follows:

Performance Category	Performance Category Weight
Quality	40%
Cost	20%
Improvement Activities	15%
Promoting Interoperability	25%

Minimum Performance threshold increased

The performance threshold, which is the minimum number of points needed to avoid a negative payment adjustment, has been increased:

- 45 points in 2020
- 60 points in 2021.

Quality Performance Category proposals for 2020 reporting period:

- Focus on high-priority outcome measures.
- Add new specialty sets that include:
  - Speech Language
  - Clinical Social Work
  - Pulmonology
  - Chiropractic Medicine
  - Endocrinology
- Will Increase the data completeness threshold for Quality measures to 70% of Medicare Part B patients for the performance period.

Cost Performance Category proposals for 2020:

- Add new episode-based measures.
- Add different measure attributions for individuals and groups.

Improvement Activities Performance Category proposals for 2020:

- Add 2 new Improvement activities.
- Modify 7 existing activities.
- Remove 15 existing activities.
- Stipulates at least 50% of a group's NPIs must perform the same activity for the same continuous 90 day performance period.

Promoting Interoperability Performance Category proposals for 2020:

- Add new reweighting standards for hospital-based groups.
  - A group is identified as **hospital-based** and eligible for reweighting if more than 75% of the NPIs in the group meet the definition of a hospital-based individual MIPS eligible clinician.
  - No change to the definition of an individual hospital-based MIPS eligible clinician.
- Will revise and reweight measures.

A fact sheet can be obtained by clicking on or going to the following site: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/594/2020%20QPP%20Proposed%20Rule%20Fact%20Sheet.pdf

2019 Promoting Interoperability Update

MIPS Exception Applications

The QPP Exception Applications for both the Promoting Interoperability (PI) performance category and Extreme and Uncontrollable Circumstances for MIPS are now available on the QPP web-site and can be completed online. They

must be **submitted by December 31, 2019.** Both applications are now available on the QPP website: **https://qpp.cms.gov/mips/exception-applications**

Promoting Interoperability Hardship Exceptions

If you are participating in MIPS during the 2019 performance year as an individual, group, or virtual group – or participating in a MIPS Alternative Payment Model (APM) – you can submit a QPP Hardship Exception Application for the PI performance category, citing one of the following specified reasons for review and approval:

- You're a small practice.
- You have decertified EHR technology.
- You have insufficient internet connectivity.
- You face extreme & uncontrollable circumstances.
- You lack control over the availability of certified electronic health record technology (CEHRT).

An approved QPP Hardship Exception will:

- Reweight your PI performance category score to 0 percent of the final score.
- Reallocate the 25 percent weighting of the PI performance category to the Quality performance category.

Extreme and Uncontrollable Circumstances

MIPS eligible clinicians who are impacted by extreme and uncontrollable circumstances may submit a request for reweighting the Quality, Cost, and Improvement Activities performance categories.

"Extreme and uncontrollable circumstances" are defined as rare events entirely outside of your control and the control of the facility in which you practice.

Last continuous 90-day Period Fast Approaching

The EHR reporting period for new and returning participants is a minimum of any continuous 90-day period from January 1, 2019 through December 31, 2019.

Security is still a top priority: The Security Risk Analysis measure is still required but it is an unscored measure. You will be asked to attest to the completion of one.

MIPS Scoring Methodology

CMS has also created a **2019 MIPS Scoring Guide** for providers interested in knowing the methodology CMS uses when assigning scores.

The guide can also be downloaded from the QPP resource library at: https://qpp.cms.gov/about/resource library

MIPS Complex Patient Bonus

The Complex Patient Bonus awards up to 5 bonus points, which is added to the final score, based on the complexity of the patients treated. This bonus is based on a combination of the average Hierarchical Condition Category (HCC) risk score of the beneficiaries treated and the proportion of dually eligible patients treated.

CMS recognizes that there are challenges and additional costs associated with the care provided to these patients.

Each MIPS eligible clinician, group, virtual group, and APM entity will be evaluated for the complex patient bonus. There is no minimum amount or percentage of dually eligible patients or patients diagnosed with a condition that has an HCC risk score required for the clinician to be scored for the complex patient bonus.

MIPS Bonus Not Worth It But Penalty Is

For all the work involved in reporting for MIPS, many physicians and practice managers across the country are coming to recognize that the 1.68% bonus given from the government's payment program may not be worth the time and resources required to participate, writes Elizabeth Woodcock in her August 20, 2019, article "Disappointed Docs Say: MIPS Is Not Worth It!" for *Medscape Medical News*.

The budget-neutrality aspect of the program means that participating physicians are getting paid ridiculously low bonuses. In July, the government announced that those with perfect scores—100 points—were getting a 1.68% bonus. This is applied to Medicare Part B reimbursements.

The bonus, therefore, is at best $840, paid in pennies and dimes throughout the year. And, if history repeats itself, that figure will drop before any payout is made.

> "The problem is no one is losing, which would be exactly what the government wants."

But despite all the downsides and all the costs, it's critical that you participate in the program!

That's because the penalties are significant. While there are hopes of gaining $840, there are realities of losing more than 7% in 2021 (the impact year for the current performance year of 2019, as the program runs in 2-year cycles).

However, there are a multitude of ways you can participate without spending thousands of dollars.

First, recognize the exemptions. Small practices—defined as 15 or fewer eligible clinicians—are exempt from the EHR portion of the program, now called "Promoting Interoperability."

Small practices also have advantages in the Improvement Activities category, with only half of the requirements needed to fulfill this component of the program.

Next, acknowledge the exemptions. One of the most time-consuming aspects of the program is the electronic exchange of information required for the Promoting Interoperability category. Part of the task participants are asked to complete—"receiving" information—can be excluded on the basis of the exemption, which reads*, "Any MIPS eligible clinician who is unable to implement the measure for a MIPS performance period in 2019."*

Finally, there's no need to go for a perfect score. Reporting 30 points is required to avoid the penalty (up from last year's 15), but it's easy to achieve. Physicians are used to reporting quality data, so that's always recommended; six metrics are scored, but more can be submitted, with the six highest scores counting.

The Improvement Activities are easy. There are more than 100 of them, and all you need is two "high-weighted" activities—or one if you're a small practice—to gain all 15 points that can be awarded for this category in the current performance year.

CMS recently announced some proposed changes to the Quality Payment Program. We'll see where those are headed when the final rule is released in November.

ABIM Embraces 'Self-Paced' Longitudinal Assessment for MOC - Ken Terry, *Medscape Medical News*, August 26, 2019

The ABIM has announced that it plans to move away from its nearly 30-year-old MOC program to a longitudinal assessment approach that will allow internists to complete ABIM-designed knowledge assessments at their own pace instead of having to sit for a comprehensive examination every 10 years.

The ABIM, which has taken the brunt of doctor resistance to MOC programs that involve make-or-break exams, chose to go this route because it decided that "one test every 10 years is probably not the best way to ensure that a doctor is staying current," Richard Baron, MD, president and CEO of the ABIM, told *Medscape Medical News.*

The ABIM has not yet announced when the new program will begin because it's still working out the details. Until it does, the group said, internists will have to continue taking the decennial exams or, alternatively, perform a certain number of "knowledge check-ins," which are self-service assessments in certain areas of medical knowledge.

The latter option is currently available for 10 internal-medicine subspecialties, and 10 more are expected to have the option in 2020.

Dr. Baron said the ABIM hopes to roll out the new MOC program to all of its subspecialties at once. Along with this new "self-paced pathway," ABIM plans to keep the 10-year exam available as an option, according to a blog post.

When the ABIM rolls out its new longitudinal assessment, doctors will receive immediate feedback on their answer, an explanation of why the correct answer is right, and educational resources related to that question. They will have to take a certain number of these assessments each quarter and each year, and they'll probably be graded every 5 years.

In addition, the questions can be answered whenever the physician has time, rather than at a certain point in time, as is the case with a traditional exam.

The new MOC program will help doctors stay current with medical knowledge and will give them a vehicle to demonstrate to their patients and colleagues and healthcare institutions that they are staying current, added Dr. Baron.

6 Steps Home Care Providers Must Take to Succeed in Medicare Advantage -- Jack Silverstein, *Home Health Care News*, July 28, 2019

The recent rule changes to Medicare Advantage (MA) from CMS have created a level of flexibility and creativity for home care participation that is nearly unchecked.

For example, the final call letter for MA plan year 2020 notes that "MA organizations have broad discretion" in determining what's called the "Special Supplemental Benefits for the Chronically Ill." Among the examples of benefits: pest control.

The new HHCN report, "The New Medicare Advantage Opportunity in Home Care," reveals the six steps home care providers must take to succeed in MA.

1. **Take both a top-down and bottom-up approach to connect with payers** -- Most MA plans come from major insurers, yet the plans themselves vary from zip code to zip code. That means in order to connect with payers, providers must take both a top-down and bottom-up approach.

   To make these connections, use national contacts to learn payers' big-picture strategies and gain national contracts; talk to local plans with supplemental benefits related to home care; and talk to local plans that serve their home care clients.

2. **Be prepared to educate payers on home care vs. home health care** -- This might sound silly, but according to a number of home care providers, major payers still struggle to understand the difference between home care and home health.

3. **Bulk up your technological infrastructure** -- "We can talk until we're blue in the face on what the value is of including personal and companion services or respite care services in a plan, but until you have the data to prove it, it's difficult for payers to really digest. It's hard for them to determine what specific services and hours they should include in the plan," Kerin Zuger, vice president of business development at Right at Home, told *Home Health Care News*.

   To capture this data, providers need to build their technological capabilities, including electronic health record systems and electronic visit verification systems. Providers must be able to connect electronically to MA plans to receive care plans and exchange patient data as part of integrated care protocols.

4. **Deliver 24-hour services** -- Though it will take at least a year for providers to begin to capture the cost and health outcomes data that payers want to see, there is one big piece of infrastructure providers can implement now to bolster their value: the ability to assist seniors and their loved ones 24 hours a day.

   In MA, 24/7 readiness means the capability to field calls and answer questions from clients and caregivers at all times. Additionally, a provider must have the technology that lets caregivers swap or reschedule shifts autonomously and lets providers quickly facilitate those reschedulings, thus reducing shift cancellations.

5. **Learn your way around CMS.gov and other sources** -- Home care providers searching for the MA contracts that are right for them will quickly come to a confusing road. As stated, MA plans don't just vary by the state, but by zip code. A home care provider serving California, for instance, would find 36 contracts in June 2019 across 22 zip codes.

   A home care provider that aims to locate the right plans for their clients needs to learn its way around several sources, most notably:
   - CMS.gov
   - Multiple spreadsheets from CMS with hundreds, thousands or even tens of thousands of data rows
   - Publicly available analyses of this data, such as the Milliman Report

6. **Learn how to read insurance plans** -- while the Milliman Report gives a great overview of plans, and the individual datasets on CMS let providers dig deeper, all of the research eventually leads to the individual plan websites and the documents that list specific benefits, known as the Explanation of Benefits (EOB) or Evidence of Coverage (EOC).

   The key takeaway here is to use all of this material in concert.

MEDICARE NEWS

New Medicare Card: Transition Period Ends in Less Than 5 Months

Starting January 1, 2020, providers must use the Medicare Beneficiary Identifier (MBI). CMS will reject claims submitted with the Health Insurance Claim Number (HICN), with a few exceptions, and reject all eligibility transactions.

Many providers are using the MBI for Medicare transactions. For the week ending August 2, providers submitted 77% of fee-for-service claims with the MBI. Protect your patients' identities by using MBIs now for all Medicare transactions. Don't have an MBI?

- Ask the patients for their card. If they did not get a new card, give them the Get Your New Medicare Card flyer in English or in Spanish
- Check the remittance advice. We return the MBI on the remittance advice for every claim with a valid and active HICN.

New QPP Access for Individual Clinicians

CMS has created a new QPP role that lets individual clinicians access MIPS performance feedback for all of their practices, virtual groups, and APM Entities. For more information please review the "Connect as a Clinician" document in the **QPP Access User Guide** or go to: https://www.qpp.cms.gov.

Questions?

If you have questions about your performance feedback or MIPS final score, please contact the Quality Payment Program by:

* Phone: 1-866-288-8292/TTY: 1-877-715-6222 or
* Email: QPP@cms.hhs.gov

2020 Update for the HPSA Bonus Payments

CR 11437 provides files for the automated payments of Health Professional Shortage Area (HPSA) bonuses for dates of service January 1, 2020, through December 31, 2020. Please make sure your billing staff is aware of these updates.

CMS creates the automated HPSA ZIP code file using the latest designations as close as possible to November 1 of each year and makes the HPSA ZIP code file available to the MACs in early December of each year.

MACs implement the HPSA ZIP code file and use it for claims with dates of service January 1 to December 31 of the following year. The MACs must make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.

Note that:

- MACs will continue to accept the AQ modifier for partially designated HPSA claims.
- MACs will continue to review samples of paid claims submitted with the AQ modifier.

Please review the Physician Bonus webpage each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment.

https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HPSAPSAPhysicianBonuses/index.html

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