



MGMA Washington Update

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Agenda



- Deficit Committee / SGR
- Longer-term payment reforms
- Proposed 2012 Medicare Physician Fee Schedule
- Federal incentives
- Administrative Simplification & Compliance

Debt/Spending “Deal”



- Immediate 10-year spending caps generating approximately \$1 trillion in deficit reduction
- Initial cuts do not impact Medicare or Medicaid
- **Second phase:** bipartisan Select Committee to identify an additional \$1.2 – 1.5 trillion in deficit reductions over 10 years
- May include entitlement and tax reforms – EVERYTHING is on the table.
- Committee is required to report legislation by Nov. 23, 2011
- Congress is required to vote, without amendment, on the committee’s recommendations by Dec. 23, 2011

Automatic backup mechanism...



- Committee must report (or congress enact) legislation that achieves at least \$1.2 trillion in savings
- If Congress fails, across-the-board spending cuts for fiscal years 2013-2021 will automatically occur to achieve the \$1.2 trillion in savings.
- Social Security and Medicaid would be exempt, Medicare would not - but beneficiaries would be held harmless
- Medicare providers would be subject to reductions of up to 2 percent in order to achieve required savings.

Deficit Reduction and the Sustainable Growth Rate Formula (SGR)



- **Opportunity from crisis?**
- **MGMA urges the Joint Committee on Deficit Reduction to include permanent repeal of the SGR as part of its deficit reduction proposal to Congress**
 - By repealing the SGR, the Joint Committee can take advantage of the best, and perhaps only, opportunity to fix the SGR.
- **MGMA advocacy - what we are doing:**
 - Grassroots Action Center: [Send a letter to your lawmaker](#)
 - Aug. & Sept. calls with state legislative liaisons to coordinate grassroots visits with lawmakers: [MGMA's talking points](#)
 - Administrators, physicians, patients - sign our joint petition with physician specialties: www.everypatientcounts.org
 - SGR LEARN released at AC: 2000+ member responses

MedPAC SGR Recommendation



- MedPAC (Medicare Payment Advisory Commission) advises Congress on issues affecting the Medicare program
- Recent recommendation outlines repeal of SGR, along with:
 - **5.9% cuts** for 3 years, followed by a 7 year freeze in payments
 - A narrowly defined set of primary care services are held harmless with a freeze in payments for 10 years.
 - Those services are estimated to only account for approximately 8% of Medicare spending.
 - Services that comprise the remaining 92% of Medicare expenditures would be subject to the 5.9% cut.
- **Next steps:** Recommendations sent to Congress for consideration
 - **MGMA letter to MedPAC opposing recommendations: Cutting and freezing payments is not the solution when total operating costs continue to rise**

Longer-Term Payment Reforms



- **Medicare shared savings program (ACO)**
- **National pilot program on payment bundling: 2013**
 - Integrated care & payment for episodes of care in Medicare
- **Value-based payment modifier: 2015**
 - Adjusts Medicare Part B payments based on quality/cost of care
- **Independent Payment Advisory Board (IPAB): 2015**
 - Non-elected board to make Medicare cost reduction recommendations
 - Prohibited from cutting Medicare benefits

Accountable Care Organizations



Overview

- Medicare Shared Savings Program begins in 2012
- Final rules released 10/20/2011
- Goal: to deliver high quality, coordinated care and lower expenditures for a patient population
- Voluntary program, with a 3-year participation agreement
 - 2 ACO 2012 start dates: April and July
- ACO must serve at least 5,000 Medicare beneficiaries

A Few Key Changes in Final Rule


- Patient assignment: preliminary prospective assignment
- Fewer quality measures (65 → 33) focused on 4 quality domains
- More favorable shared savings terms for ACOs
- Additional flexibility for fraud, waste and abuse waivers



Proposed 2012 Medicare Physician Fee Schedule

Proposed 2012 Medicare Physician Fee Schedule



- Includes numerous changes to Medicare Part B payment, policies and incentive programs
- Released July 1, 2011
- 2012 conversion factor: \$23.9635 (2011 CF: \$33.9764)
 - Represents a 29.5% cut
 - Congress must intervene to prevent cut
- Read the MGMA Fee Schedule [Analysis](#) 
(<http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=1366895>)
- MGMA submitted [comments](#) to CMS
(<http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=1367344>)
- Final 2012 fee schedule expected in November

2012 Proposed Fee Schedule: Payment Changes



- **Adjusts certain RVUs and examines misvalued codes**
 - Continues PE RVU transition to PPIS data source, results in payment shift among specialties (3rd year of 4 year transition)
 - 5-year Work RVU Review
 - CMS, AMA review potentially misvalued codes
 - Focus on E/M codes and site of service anomalies
- **GPCIs**
 - 1.0 work GPCI floor expires on Dec. 31, 2011
 - The 1.5 work GPCI floor for Alaska and 1.0 for frontier states is permanent.
 - New data source on 2 bedroom rent as proxy for physician office rent
 - **MGMA comments: use *commercial* data for GPCI updates**
- **Modifies Part B Drug Payments**
 - CMS proposes to substitute Average Manufacturer Price (AMP) for Average Sales Price (ASP) if ASP exceeds AMP by 5%+ for 2 quarters
 - **MGMA comments: remove this price substitution proposal**

2012 Proposed Fee Schedule: Payment Changes



- **Expands the Multiple Procedure Payment Reduction**
 - Reduces payment for **PC** of MRI, CT and ultrasound (currently impacts TC).
 - 50% reduction for second and subsequent services (Impacted services : Addendum F)
 - **MGMA comments: Arbitrary cut - remove this provision**
- **Adjusts payment for certain services provided within a 3-day window of a inpatient hospital stay**
 - Would pay physician's the facility rate (instead of the non-facility rate) for the physician component of diagnostic services and non-diagnostic services that are:
 1. Performed within 3 days prior to hospital inpatient admission
 2. Are related to the admission
 3. Are performed in a physician practice that is wholly owned/operated by the hospital
 - **MGMA comments: Lowers payment, creates confusion and would require complex billing - withdraw this proposal**

Medicare Annual Wellness Visit

Focuses on identification of risk factors, prevention and providing personalized health advice.

- **Proposed fee schedule changes for 2012 AWW:**
 - Requires a “health risk assessment” – an evaluation tool to collect information used to provide personalized health information.
 - HRA can be completed prior to, or part of, AWW
 - HRA has a required number of elements and will collect information on:
 - Health status, injury risks, modifiable risk factors, urgent health needs
 - Should only take 20 minute to complete
 - Can be done using forms, online or over phone
 - No proposed change in payment
- **MGMA comments: scale back this requirement (more flexibility) and increase payment to reflect the additional work/resources required**





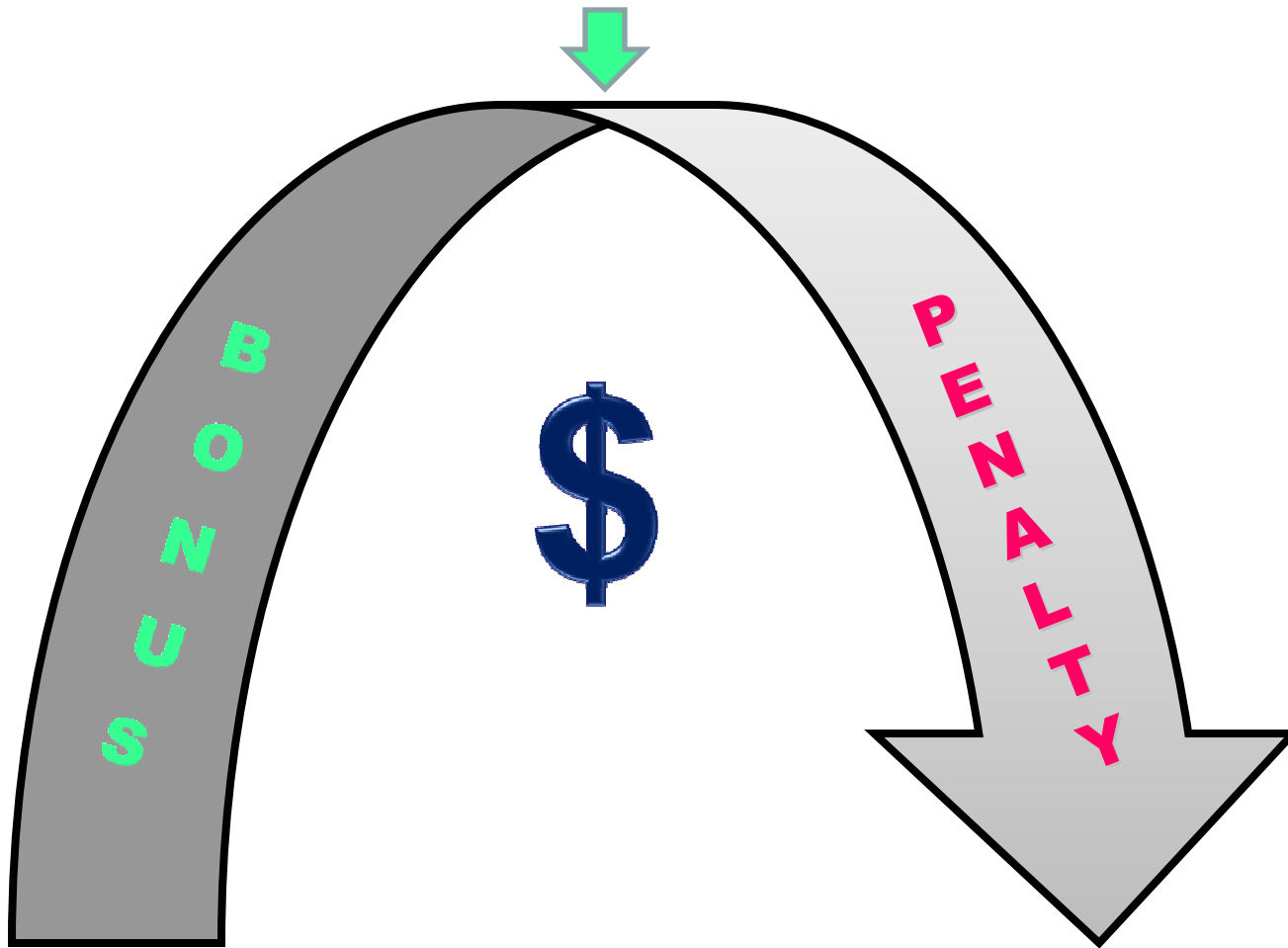
Federal Incentives

Incentives



Years	Bonus Amount	Eligible Specialties / Professionals	Additional Requirements	2011
Primary Care Bonus				
2011-2016	10% of Part B payments for primary care services.	Family/internal medicine, geriatrics, pediatrics, NPs, PAs, CNS.	To qualify, 60% of a provider's Medicare charges must be office, nursing facility or home visits.	EPs identified based on 2009 data. Payment distributed on quarterly basis based on 2011 charges.
HPSA General Surgery Bonus				
2011 – 2016	10% of Medicare charges for eligible surgery.	General surgeons furnishing major procedures (billed as 10-day or 90-day global period).	Must be practicing in a Health Professional Shortage Area (HPSA)	Procedures eligible: 4,300 10-day and 90-day procedures Distributed on a quarterly basis.

Staying on Top of the Incentive Curve



E-prescribing Program



Year	Bonus	Penalty
2009	2%	None
2010	2%	None
2011	1%	None
2012	1%	1%
2013	0.5%	1.5%
2014	none	2%

E-prescribing Bonus 2011 – 2014

- EP must submit 25 instances of e-prescribing during the calendar year.
- Report Gcode G8553 using claims, registry, or EHR.
- Must have 10%+ of Medicare allowed charges from the following codes:
90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

2012 E-prescribing *Penalty*



- CMS determines methodology and reporting period
- If EP is penalized, the amount will be deducted from each claim as it is processed (beginning 1/1/2012)
- Limited hardship exemptions available
 - EP/group practice is in a rural area with limited high speed internet access
 - EP/group practice is in an area with limited available pharmacies for electronic prescribing
- Providers who are not penalized:
 - Successful e-prescribers. New providers. EPs who, in first 6 months of 2011, have a low level of Medicare claims from the denominator set of codes (fewer than 100 claims or less than 10% of Medicare allowed charges).

CMS Finalizes New Exemptions For 2012 eRx Penalties



- **New exemption categories:**
 - Unable to electronically prescribe due to local, State or Federal law or regulation (prescribes controlled substances).
 - Limited prescribing activity (NP who may not write Rx's under his/her own NPI #).
 - Has insufficient opportunities to report the electronic prescribing measure due to limitations of the measure's denominator (ex. surgery practices).
 - Have registered for Medicaid/Medicare EHR Incentive program and use a certified EHR technology.

CMS Finalizes New Exemptions For 2012 eRx Penalties



How to apply for an exemption:

- Submit via web-based [portal](#) (or mail for GPRO participants)
 - https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234
 - View the portal [user manual](#):
https://www.qualitynet.org/imageserver/pgri/documents/Communication_Support_Page_User%20Manual.pdf
- Justification statement required
- Exemptions must be requested by **November 1, 2011**
- CMS will review exemption requests on a case-by case basis (no appeals process)
- Submit your request ASAP to avoid claims reprocessing in 2012
- View the final rule at: <http://www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22629.pdf>

Applying for eRx hardship exemption



Communications Support System - Windows Internet Explorer
https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234

File Edit View Favorites Tools Help

Welcome, PQRIGuest Log In Help Search: Everywhere

Inside this Community Related Communities

New Page

U.S. Department of Health & Human Services www.hhs.gov

CMS Centers for Medicare & Medicaid Services

Communication Support Page

User Information * Required Field

Legal Business Name (as enrolled in PECOS)*:

TIN (Last 4 digits)*: NPI*:

Email*: Confirm Email*:

Contact Information (Requestor)

First Name*: M.I.: Last Name*:

Address 1*: Address 2:

City*: State*:

Phone*: Zip Code*:

Ext: Requestor Relationship*:

Request NPI Level Feedback Report

Program Year: 2011 PQRS Feedback Report eRx Feedback Report eRx Payment Adjustment Feedback Report

Request Hardship Exemption (Select one **AND** complete Justification for Hardship Exemption)

I registered to participate in the Medicare or Medicaid EHR Incentive Programs for 2011 and have adopted Certified EHR technology
Registration ID # CMS EHR Certification ID #

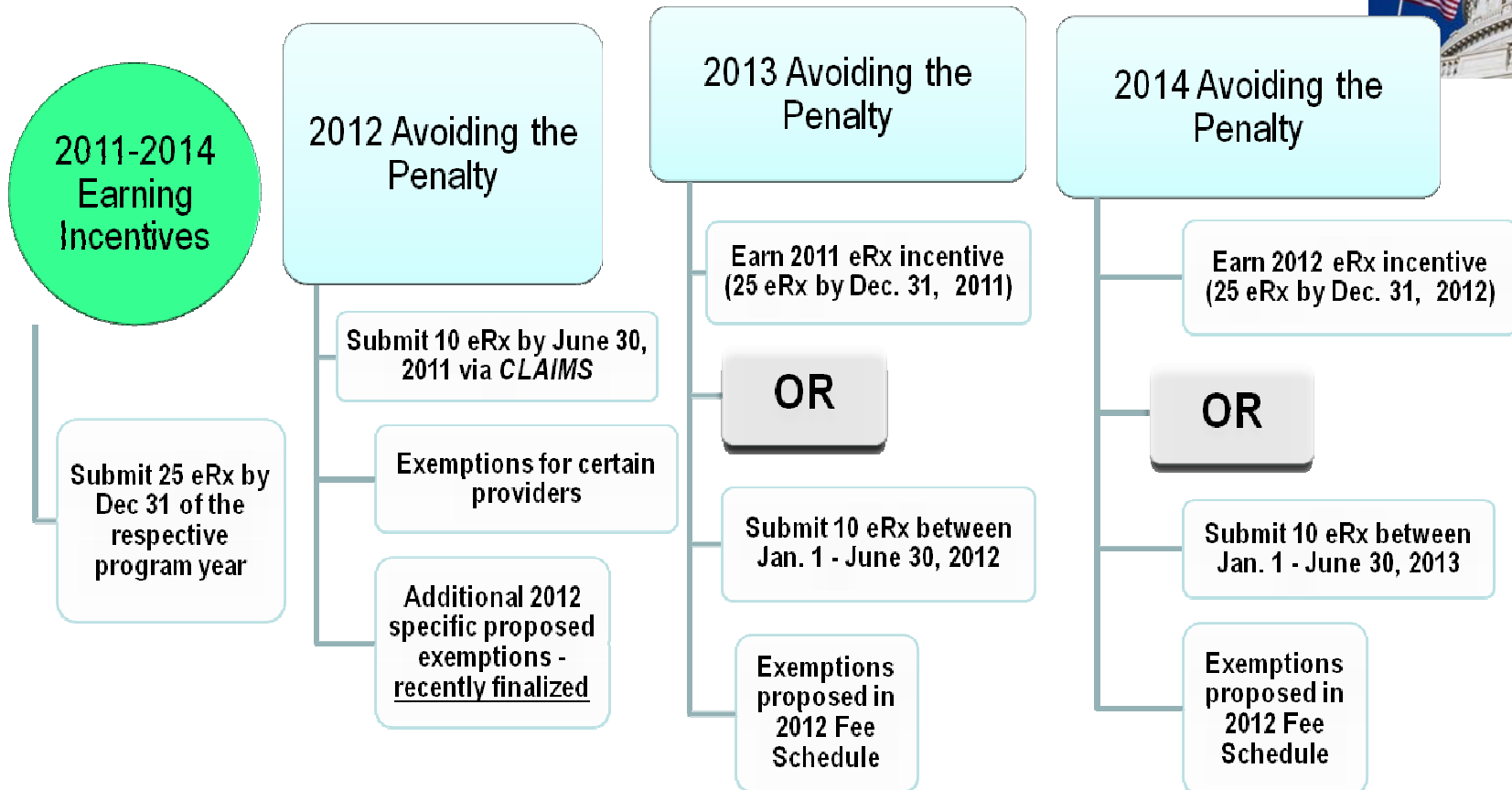
I have an inability to electronically prescribe due to local, State, or Federal law or regulation

I have limited prescribing activity

12:05 PM 10/18/2011

https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234

Proposed Changes to E-prescribing



Proposed Changes to E-prescribing



- Key changes: avoiding the 2013 and 2014 penalties
 - Report via claims, EHR or registry
 - Report on any eRx (not restricted to reporting in association w/ an eligible patient visit)
 - Additional reporting period added
 - 2 additional hardship exemptions added
 - Unable to prescribe due to local, State or Federal law or regulation
 - Prescribed fewer than 100 times during a respective 6 month reporting period

PQRS

- 2011: 1% bonus for reporting quality measures
 - Extra 0.5% bonus per year available for successful participation in Maintenance of Certification program
- 2012-2014: .5% bonus
- Penalties begin in 2015 (1.5%), based on 2013 PQRS
 - Increase to 2% in 2016
 - **MGMA comments: Oppose financial penalties, but if implemented reporting and performance years should be the same**
 - **Deem meaningful users as exempt from penalties**
- Can report on individual measures or measures groups
- Reporting options: claims, registry, EHR
- Individual professionals or groups can participate



Proposed Changes to 2012 PQRS



- New specialty-specific reporting for: family practice, general practice, internal medicine and cardiology
 - Must report 1 (of the EPs required 3 individual measures) from a set of 7 “core” measures to target cardiovascular conditions.
 - **MGMA comments: physicians should have full discretion to choose which measures are most clinically relevant to the care they provide**
- Fewer 6-month reporting period options. **Only** available for registry-based, measures groups reporting.
- New definition in Group Practice Reporting Option (GPRO)
 - GPRO consolidated: 1 program, for groups with 25+ EPs
 - Reporting criteria varies for groups with 25-99 and 100+ EPs
 - **MGMA comments: maintain current definition of group practice (2 or more EPs)**

EHR Incentive Program (CMS /ONC)



- Beginning in 2011, Eligible professionals who use a “certified” EHR in a “meaningful” way can qualify for up to \$44,000 over five years under Medicare, or up to \$63,750 over six years under Medicaid.
 - Penalties begin in 2015 for EPs who are not meaningful users up to -5% in 2019
- Online registration for the program started Jan. 3 at https://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp
- The “meaningful use” requirements: http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage
- Details on meeting core and menu set MU measures: <https://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf>
- Full list of certified products available at: <http://onc-chpl.force.com/ehrcert>
- For more information on the program visit:
 - ONC site at: http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_home/1204
 - CMS site at: <http://www.cms.gov/ehrincentiveprograms/>
 - MGMA site at: <http://www.mgma.com/meaningfuluse/>

Meaningful Use

- No double dipping with Medicare and Medicaid
 - Or with Medicare MU and e-prescribing
- Only certain states are ready for 2011 Medicaid MU
 - Check the status of your state's Medicaid MU program:

<http://www.cms.gov/apps/files/medicaid-HIT-sites/>

Payments and Next Steps

- \$850+ million in bonuses paid to EPs, hospitals (Sept. 2011)
- MU Stage 2
 - Final rule expected in early/mid 2012
 - Stage 2 scheduled to begin in 2013, but may be pushed to 2014



Proposed 2012 PQRS/MU Pilot



- Proposed 2012 Physician Fee Schedule includes a pilot to report PQRS and Meaningful Use quality measures together.
- Reporting period is the entire year
 - Despite 90 day reporting period for 1st year of MU
- Data submitted on Medicare Part B patients only
 - Differs from MU, in which reporting is on all applicable patients
- Report the quality measures required for MU
 - More measures than required for PQRS
- Reporting would satisfy requirements of BOTH the MU and PQRS programs



Administrative Simplification & Compliance

Administrative Simplification



- ACA included numerous Admin. Simp. Provisions
 - Standardize electronic funds transfers / electronic claims attachments / operating rules
 - Establish a health plan identifier
 - Explore standardized health plan enrollment and claims edits
- Standardized operating rules → Ease burdens and costs for practices
- Recent CMS rule on operating rules for HIPAA transactions would make it easier for practice to:
 - Check patient eligibility and financial responsibility
 - Monitor status of submitted claims
 - **MGMA comments: Support standardized operating rules, request that CMS also include Acknowledgements transactions, continuing to push for standardized machine-readable ID cards**
- Significant fines on health plans for noncompliance

Medicare Enrollment



- MGMA participates in CMS “PECOS Power User Group”
- CMS focusing on enrollment as a way to prevent fraud
 - Emphasis on having up to date record in PECOS
- Ordering/referring edits – on hold, no date for second phase of implementation

NEW: Medicare Revalidation Initiative

- CMS will revalidate **ALL** Medicare providers by March 2013
 - Only those who revalidated/enrolled on or after Mar. 25, 2011 are exempt
 - Providers must respond to revalidation request within 60 days
- Learn more: CMS MLN Matters [Article on Revalidation](https://www.cms.gov/MLN MattersArticles/downloads/SE1126.pdf)
(<https://www.cms.gov/MLN MattersArticles/downloads/SE1126.pdf>)
- **MGMA communicating to CMS initial member concerns on revalidation**

5010 transactions / ICD-10



- 5010 replaces 4010
 - Next generation of the HIPAA electronic transactions
 - Compliance date is January 1, 2012
- ICD-10 replacing ICD-9 for outpatient diagnosis codes
 - ICD-10 vs ICD-9: Much more granular code set
 - MGMA concerned that adoption will disrupt the claims payment system and the cost for practices (Study shows \$285,195 for a 10-physician practice)
 - Compliance date Oct. 1, 2013

5010 Transition

- MGMA Survey on V5010 preparedness
 - Survey closed October 21st, results available shortly
- Test your claims transactions in the V5010 format **prior to the Jan. 1 deadline!**
 - Recent (and ongoing) opportunities to test 5010 transactions
 - CMS encourages all trading partners (providers, clearinghouses and vendors) to participate and test compliance efforts



Plan Not Ready? Manage Your Risk



- If a plan announces it will not be ready for V5010 by Jan. 1, determine if they will be accepting 4010 claims (though they would not be in compliance)
 - Request confirmation in writing
 - Ensure that your PMSS can generate the 4010
 - Let CMS know directly at:
https://www.cms.gov?Enforcement/05_HowtoFileaComplaint.asp#TopOfPage or, contact MGMA at govaff@mgma.com
- Contact a major clearinghouse early in the process- they may be able to convert your 4010 claims to 5010
 - Some billing services can perform this as well
- MGMA: Working with AMA on PMS vendor outreach, directory
 - MGMA to advocate for CMS contingency plan to avoid cash flow disruption

Thank you!

Q&A





Appendix

2010 Reprocessing



- Certain Medicare claims under/overpaid in 2010 (Jan.- June)
 - Retroactive changes from ACA
 - Technical correction to 2010 fee schedule
- CMS February announcement:
 - CMS “will begin to reprocess these claims over the next several weeks”
 - Many contractors are still undergoing reprocessing
 - Do not resubmit claims
 - Underpaid claims with submitted charges lower than the revised 2010 fee schedule amount will not be automatically reprocessed.
 - Additional beneficiary cost-sharing is waived
 - CMS will waive the one-year limit to request reopening of claims

Recovery Audit Contractors (RACs)



- Identify and recoup overpayments and refund underpayments in federal healthcare programs
- Permanent RAC program in Medicare
 - Has mostly focused on Part A audits to date
- ACA expanded RACs to Medicare Parts C and D and to Medicaid
- MGMA letter to CMS on RAC expansion, emphasizes standardization between RAC programs and reducing the burden on providers
 - <http://www.mgma.com/rac/>

HIPAA: Accounting of Disclosures Proposed Rule



- New requirement – patient has a right to a written “access report”.
 - All “access” **including TPO**. Must include date, time, person/entity and, if available, what information was accessed and action by user (e.g., modify, delete)
- Proposed rule goes well beyond the law
- Would place a burden on practices and provide an unwieldy amount of information to patients.
- Requires practice to collect information on accessing electronic PHI by the practice AND its business associates
- Limited to previous 3 years (vs. 6 years currently)
- Implementation: 1/1/2013 (if EHR was adopted after Jan. 2009) OR 1/1/2014 (if adopted prior to 2009)
- Will require amended NPPs/BAA's and review of software capabilities

2012 Proposed Fee Schedule



Key proposals:

- Adjusts certain RVUs and changes payment for misvalued codes
- Expands the Multiple Procedure Payment Reduction
- Adjusts payment for services provided by select providers within a 3-day window of a inpatient hospital stay
- Modifies Part B Drug Payments
- Expands telehealth services to include smoking cessation
- Adds a new required component to the Medicare Annual Wellness Visit
- Changes PQRS and creates a PQRS-Meaningful Use pilot
- Changes e-prescribing incentive and penalties

Independent Payment Advisory Board (IPAB)



- The ACA established an unelected 15-member IPAB to extend Medicare solvency and reduce spending growth
 - spending target system
 - fast-track legislative approval process
- 2015 is the first year IPAB has the authority to make recommendations
- Legislation that would eliminate the IPAB: H.R. 452 and S. 668
- IPAB usurps congressional oversight of the Medicare program
- MGMA members are encouraged to participate in our grassroots campaign in support of H.R. 452 and S. 668

Medical Liability Reform



- **H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2011**
 - \$250,000 limit on noneconomic damages
 - States could maintain their own laws on damages
 - Limit attorneys' fees
 - Establish periodic payments of future damages
 - “Fair share” rule that allocates damage awards in proportion to fault
 - CBO estimate: Would reduce the federal deficit by almost \$40 billion over 10 years
- **Next step: vote of the full House (passed by House Energy and Commerce and Judiciary Committees, state opt-out amendments expected)**

Advocacy – get involved



MGMA Advocacy Initiatives

- Current grassroots focus:
 - Repeal the SGR. Congressional action needed before 29.5% cut in 2012.
 - Sign a petition (at EveryPatientCounts.org) to call upon Congress to enact a permanent solution to the SGR.
- Additional advocacy priorities:
 - Medical liability reform. Support H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011
 - Repeal the Independent Payment Advisory Board (IPAB)



Physician Compare



Website containing information on Medicare providers

- [http://www.medicare.gov/find-a-doctor/\(X\(1\)S\(240obwmeeqwpvu55404fig55\)\)/provider-search.aspx](http://www.medicare.gov/find-a-doctor/(X(1)S(240obwmeeqwpvu55404fig55))/provider-search.aspx)

Mandated by ACA with 1/1/2011 launch date

- **Phase I:** Currently contains name, practice location, specialty, PQRS participants
- **Phase II:** Will contain info on successful eRx'ers, MU participants, and PQRS GPRO participant quality performance rates
 - EPs will see information before publicly posted, results w/ < 25 patients worth of data will not be included

MGMA has advocated that any information must be up-to-date, accurate and providers should be able to easily correct any errors