

HFMA Spring Institute-Lone Star Chapter

Loading the Bases: Preparing for Medicare Payment Changes (Budget Act, OPPS, and MIPS)

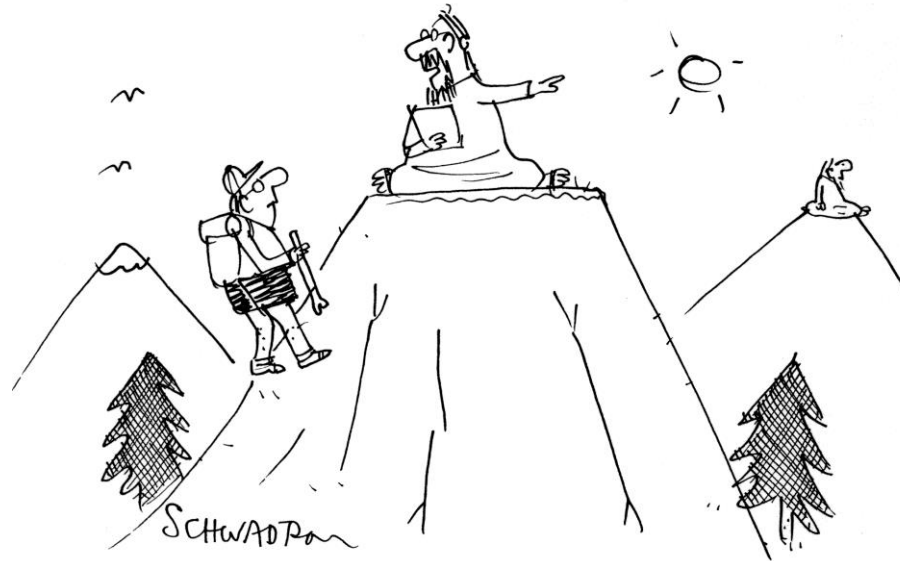
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 **HALL
RENDER**
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Medicare:

"Complex regulatory structure."



"Truth and enlightenment are on another peak. I do medicare explanations."

Objectives

- Overview of Section 603 of the Bipartisan Budget Act of 2015
 - Amendment to the Social Security Act
 - Impact on OPPS Coverage
 - Potential Impact on Medicare Provider-Based Rule



Objectives

- Overview of the legislative changes under the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA")
 - Change in Reimbursement Models
 - Introduction of Merit-Based Incentive Payment Systems ("MIPS")
 - Introduction to Alternate Payment Models ("APM")



Bipartisan Budget Act of 2015

- Section 603 of the Budget Bill of 2015
- Amendment to Social Security Act § 1833(t)
 - Impacts hospital services provided in off-campus outpatient department of a provider as defined in 42 CFR § 413.65(a)(2)
 - Medicare provider-based rule
 - Services provided in off-campus departments excluded from coverage as OPD services effective **January 1, 2017**
 - Only those departments billing on the DOE are grandfathered
 - Date of enactment is November 2, 2015
 - No grandfather for "under development" sites

Bipartisan Budget Act of 2015

- Amendment to Social Security Act § 1833(t)
 - On-campus department services not impacted
 - Remote location "campus" services not impacted
 - Different definition than provider-based rule; remote location is considered an off-campus location
 - Off-campus ED services (furnished by a "dedicated ED") not impacted
 - Outpatient services paid under a fee schedule not impacted
 - CAHs not impacted
 - "Provider-based entities" not impacted (ex. RHCs)

Bipartisan Budget Act of 2015

- Open Questions
 - How do hospitals enroll and bill for non-grandfathered sites?
 - How will CMS pay for services not covered by another applicable payment system?
 - Multi-campus hospital structure - JVs & Management Contracts?
 - What happens to a site that receives a provider-based revocation back to pre-DOE (November 2, 2015)?
 - What happens if voluntary refund required from lack of compliance with provider-based regulation?

Bipartisan Budget Act of 2015

- Open Questions
 - Can grandfathered site relocate, expand, or add new footprint and/or new services?
 - 340B Child Sites after 12/31/2016?
 - Grandfathered site undergoes CHOW to new Main Provider number?
 - I/P Campus moves and leaves behind O/P only at old campus?
- OPPS Rule will Implement Section 603
 - CMS accepting "pre-comments to consider for proposed CY 2017 HOPD regulation due out mid-summer
 - Provider-BasedDepartments@cms.hhs.gov.

Bipartisan Budget Act of 2015

- 2/5/16 Letter from Committee on Energy & Commerce
 - Requested industry commentary by 2/19/16
 - AHA submitted 13 page response on 2/12/2016?
 - <http://www.aha.org/advocacy-issues/letter/2016/160212-let-site-neutral.pdf>
- 4/27/16 Bipartisan Senate Letter asking CMS for flexibility in implementing site-neutral HOPD changes
 - AHA Action Alert; signatures accepted through 5/10/16
- Potential for payment policy flexibility?

Definition of Campus

- What is "On Campus" ?
 - "Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus."
 - Affects:
 - Ability to open new provider-based HOPD services given Budget Act changes
 - RO interpretation and how do they measure?
 - Will OPPS rule offer further guidance?

Definition of Campus

- Takeaways
 - "Main buildings" not defined – CMS generally interprets as primarily inpatient care location/building
 - Only main buildings enlarge footprint via 250 yard rule
 - Region 5 rarely has approved discretionary expansion
 - Maybe if nothing but open space between main buildings and new structure

Key Takeaways for Budget Act Changes

- OPPS coverage continues for grandfathered off-campus departments, on-campus departments, HOPDs "on campus" of a remote location, and DEDs
- "New" off-campus departments lose OPPS coverage on January 1, 2017
- Rulemaking to address open questions: be sure to comment!
- Consider financial impact for budget purposes = will Medicaid and private pay follow?
- Potential exists for payment policy flexibility (we hope)

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Summary of MACRA

- Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") repeals SGR
- Positive updates in Physician Fee schedule for 4.5 years
- Implements MIPS, a new quality reporting system
- Incentives to participate in Alternative Payment Models ("APMs")

The Old Rule: SGR

- Sustainable Growth Rate ("SGR") Formula.
 - A formula designed to limit spending on physicians' services below the targeted rate of growth.
 - When spending increases exceed the target, payments were automatically reduced across the board.
- SGR has continuously called for steep cuts in payments to physicians, and Congress has acted to avert the payment reductions.
- Permanent repeal of SGR formula, avoiding the 21.2% Medicare physician payment cut that was scheduled to take effect on April 1, 2015 and preventing future cuts.

MACRA: SGR Repealed and Positive Annual Updates

- MACRA: Positive updates for physician services for 4.5 years
 - 0% for January - June 2015
 - 0.5% for July 2015-2019
 - 0% for 2020-2025
 - 0.75% for eligible APM participants and 0.25% for all others in 2026 and beyond

Two Paths for Eligible Professionals

Path 1 – MIPS Participant

- Paid based on the Physician Fee Schedule throughout the year.
- Must report to MIPS Quality Reporting System.
- Will receive positive or negative payment adjustment depending on performance on MIPS.

Path 2 – APM Participant

- Not subject to MIPS reporting.
- 5% Bonus Payment for 2019-2024.
- In 2026 and beyond, APM participants will receive 0.75% annual update on the fee schedule whereas MIPS participants receive 0.25% for the same years.

MIPS "Eligible Professionals"

- Eligible Professionals subject to MIPS reporting beginning in 2017:
 - Physicians (MD, DO)
 - Physician Assistants
 - Nurse Practitioners
 - Clinical Nurse Specialists
 - Certified Registered Nurse Anesthetist
- Other professionals paid under the Physician Fee schedule may be included in future years (i.e. therapists, midwives, social workers).

MIPS "Eligible Professionals"

- Who is Exempt:
 - Low Volume Threshold- Medicare billing charges less than or equal to \$10,000 **and** provides care for 100 or fewer Part B enrolled Medicare beneficiaries.
(Proposed Rule)
 - Participants in the APM Models
 - First year Medicare Providers

MACRA: Merit-Based Incentive Payment System ("MIPS")

- Current penalties under PQRS, EHR/Meaningful Use, and VBM will end at the close of 2018.
- In 2019, MIPS will be the only Medicare quality reporting program for physicians.
- Four categories to MIPS, building off concepts in PQRS, MU and VBM
 - Quality-*Proposed Rule- 50% for 2019; 45% for 2020; 30% for 2021*
 - Cost-*Proposed Rule- 10% for 2019; 15% for 2020; 30% for 2021*
 - Advancing Care Information- *Proposed Rule- 25%*
 - Clinical Practice Improvement Activities- *Proposed Rule- 15%*

Quality 50%

- Replaces the PQRS Program
- Proposed Rule (issued 4/27/2015) released Proposed Measures for 2017 reporting. Proposed Rule Criteria:
 - Selection of 6 Measures (out of almost 300 measures)
 - 1 Cross-Cutting Measure and 1 outcome measure, or another high priority measure if outcome measure is not available
 - There are specialty measure sets to help identify which measures are applicable to them
 - Different requirements for non-patient facing clinicians

Cost (10%)

- Replaces the Value Based Modifier (VM) Program
 - continuation of two measures from VM Program
 - Total per capita costs for all attributed beneficiaries
 - Medicare Spending per Beneficiaries
 - Additionally more than 40 episode specific measures
 - (see Proposed Rule, Table 4 and 5 for full list)
- Goal- clinicians that deliver more efficient, high quality care achieve better performance.
- The Score would be based on Medicare claims; meaning no reporting requirement for clinicians.

Advancing Care Information (25%)

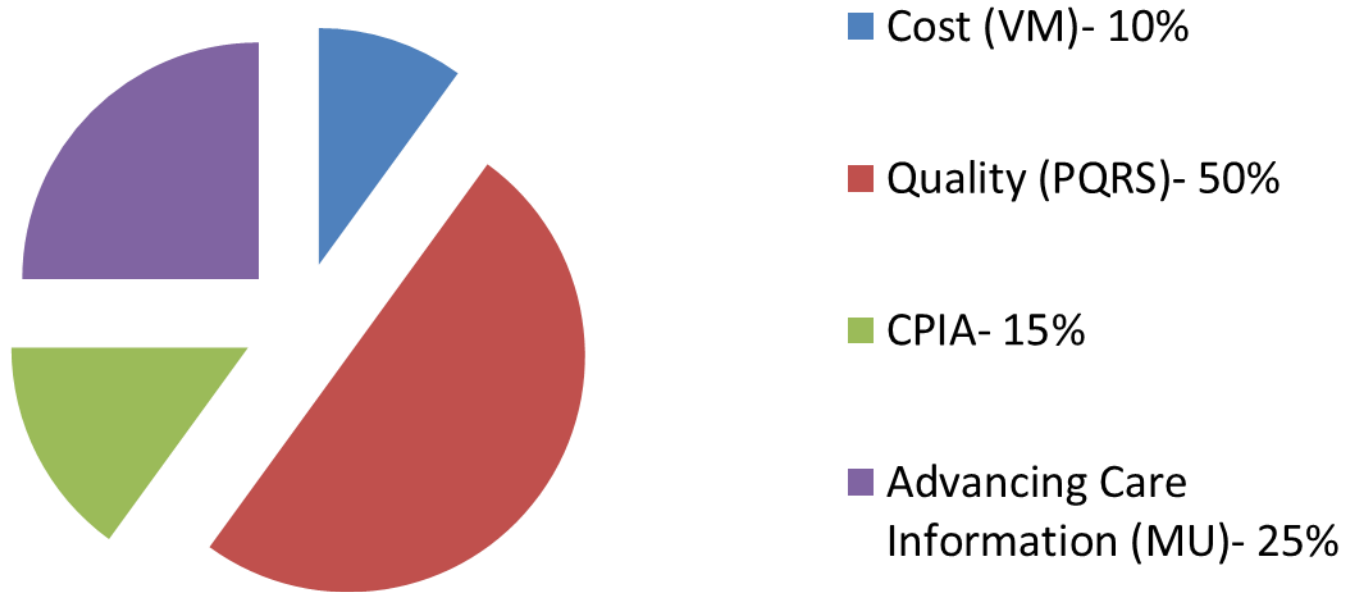
- Replaces the EHR Meaningful Use Program for physicians
- Clinicians chose to report customizable measures that reflect how they use EHR Technology in their day-to-day practice
- Base Score, Performance Score, Bonus Points
- Differences from EHR
 - Can participate as a group
 - Would no longer require all-or-nothing EHR measurement

Clinical Practice Improvement Activities (15%)

- New Category; does not replace any current program
- Clinicians may select activities that match their practice's goals from a list of more than 90 options (in the proposed rule). Examples:
 - Expanded practice access (24/7 access, telehealth access,)
 - Population management (use QCDR to generate regular feedback reports)
 - Care coordination (timely communication of test results)
 - Beneficiary engagement (provide coaching between visits)
 - Patient safety and practice assessment (consulting PDMP prior to issuing CSII)

Composite Performance Score

MIPS Composite Performance Score



MIPS: Penalties & Bonuses

- MACRA - Bonuses and Penalties
 - 2015-2018: PQRS, MU, and VBM will continue
 - 2019: 4%
 - 2020: 5%
 - 2021: 7%
 - 2022: 9%
 - Extra bonuses up to 10% are possible for exceptional MIPS scores for years 2019-2024.

MIPS Penalty/Bonus Example

- Facts - 300 provider practice with \$100,000 in Medicare Part B reimbursement per provider. Total Medicare Part B reimbursement totals \$30,000,000.
- MIPS Penalty/Bonus for Year 2022 at 9%:
 - $\$30,000,000 \times 0.09 = \2.7 million
 - Maximum positive adjustments totaling = **+\$2.7 million**
 - Maximum negative adjustments totaling = **-\$2.7 million**

Alternative Payment Models

Model tested by Centers for Medicare and Medicaid Innovation

Demonstration required by federal law

Demonstration under the Health Care Quality Demonstration Program

Accountable Care Organization ("ACO") under the Medicare Shared Savings Program



Statutory
Definition of
APM

Alternative Payment Model

- Statute requires that an APM entity participating meet the following criteria:

EHR

- Requires the use of certified EHR Technology

Measures

- Provides for payment for covered professionals services based on quality measures similar to those under MIPS

Risk

- Bears financial risk for monetary losses under such a model that are in excess of a nominal amount; OR
- Is a medical home expanded under Section 1115(c), under which a model tested by the CMMI can be expanded and even applied nationwide

Alternative Payment Models

- Proposed Rule list of models that qualify as Advanced APMs for first performance year:
 - Comprehensive End Stage Renal Diseases Care Model
 - Compressive Primary Care Plus
 - Medicare Shared Savings Program-Track 2
 - Medicare Shared Savings Program-Track 3
 - Next Generation ACO Model
 - Oncology care Model Two-Sided Risk Arrangement (available in 2018)

Alternate Payment Models

- **What is an APM participant:** Clinician must receive enough of their payments or see enough of their patients through Advanced APM
- *Clinician must meet payment or patient requirement*

Requirement for Incentive Payment for Significant Participation in an Advanced APM						
Payment Year	2019	2020	2021	2022	2023	2024---
% of Payments through APM	25%	25%	50%	50%	75%	75%
% of Patients through APM	20%	20%	35%	35%	50%	50%

Alternate Payment Models

- Incentives to become an APM participant
 - Not required to participate in MIPS
 - Eligible for 5% Bonus payments for 2019-2024
 - In 2026 and beyond, annual update to Physician Fee Schedule of .75% for APM; whereas non-APM participants will receive .25% annual update for the same years.

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Key Takeaways for MIPS

- **REPORTING STARTS IN 2017 FOR 2019 ADJUSTMENTS**
- **Budgeting Issue-** This is budget neutral. It will be difficult to project reimbursement in advanced.
- **Agreements-** Physician compensation, supply pricing schedules from volume to value.
- **Data/Reporting-** Ensure that the infrastructure is available to compile, analyze, and report data. Proposed Rule allows third parties to submit data.
- **Personnel-** Three massive systems combining; may include committees of people working together to ensure smooth transition.
 - **Comment Period to Proposed Rule Ends June 27, 2016**



Please visit the Hall Render Blog at <http://blogs.hallrender.com> for more information on topics related to health care law.

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