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Welcome to PMI’s Webinar Presentation

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Meet the Presenter…

On the topic:
Quality and Cost – How They Impact Practice Reimbursement

Maxine Collins
MBA, CPA, CMC, CMIS, CMOM
Faculty
Practice Management Institute
"The Hunger Games" – Quality and Cost

Impact on Reimbursement

Presented by:
Maxine Collins
MBA, CPA, MCM, CMOM, CMIS
Faculty/ Consultant
Practice Management Institute

Introduction

• “The Quality Games” are on –
  – PQRS – Pay for Performance
  – QRURs – How will you “rank”?
  – EHR – Goals for interoperability
  – Integrated health care (Higher quality of care at lower costs)
  – Value-based purchasing (Leading to the MIPS program)
    • Goals of CMS
    • Goals of Private Carriers
Huge Victory for Medicine: No More SGR!

“Shout it from the rooftops: Success (finally)! Last night, medicine achieved the biggest victory since the passage of Texas' 2003 tort reform liability protections. Just hours before a 21-percent pay cut to physicians was set to take effect, the Senate approved the bill to repeal Medicare's fatally flawed Sustainable Growth Rate (SGR) formula, permanently and immediately.”

("Huge Victory for Medicine," 2015)
Headlines

From *The National Review*:
“The SGR Fix Will Bust the Budget”  
(Cannon, 2015)

From *MedCity News*:
“Why the Doc Fix solution is a Trojan Horse that will undermine healthcare”  
(Girgis, 2015)

From *National Policy Analysis*:
“SGR Repeal Bill Will Harm Medicare Patients”  
(Hogberg, 2015)

Summary of Bill

• The bill, H.R. 1470 and S. 810, is:
  – “an updated version of the policies set forth in last year’s bipartisan, bicameral Medicare payment reform bill.”

• Key provisions of H.R. 1470 and the Senate bill include the following:
  – The SGR would be repealed immediately.
  – Positive annual payment updates of 0.5 percent would be provided for four-and-a-half years, beginning July 1.
  – The current Medicare quality reporting programs would be replaced with a simplified and consolidated merit-based incentive payment system, or MIPS.
  – A 5 percent incentive payment for physicians is provided for physicians who participate in alternative payment models and meet certain thresholds.
  – Provisions similar to the Standards of Care Protection Act are included.

("Congress Unveils Bipartisan SGR Repeal," 2015)
Overview of SGR Repeal and Reform Proposal

- Physician organizations have long-sought repeal of the Sustainable Growth Rate (SGR) formula.
- The Congressional Budget Office (CBO) estimates that repealing the SGR and freezing payments at their current level for the next 10 years would increase spending by approximately $138 billion. Such an investment in funds needs to be accompanied by fiscally responsible fundamental reform of the Medicare fee-for-service (FFS) payment system. We are committed to developing such a reform proposal.

Reform development process and principles – Numerous sources of valuable input were considered, including:
- Staff meetings with physicians, physician organizations and other stakeholders;
- A series of Health Subcommittee hearings in Ways and Means and Energy and Commerce on reforming the Medicare physician payment system;
- Responses from over 70 physician organizations to a Ways and Means Committee Republican member letter asking for guidance on incorporating quality and efficiency into the Medicare payment system; and
- Responses from a similar number of physician organizations to an Energy and Commerce bipartisan member letter requesting how to address the SGR situation.

(Overview of SGR Repeal, 2013)

Summary of Goals

Reform must:
- Not increase the deficit;
- Involve the physician community and other stakeholders;
- Foster clinically meaningful (not government determined) care for patients;
- Encourage achievable improvements in quality, efficiency, and patient outcomes based on physician-endorsed measures;
- Be applicable to all specialties, practice arrangements, and geographic locations;
- Reward the value rather than the volume of services;
- Motivate all stakeholders to adopt reforms; and
- Strengthen Medicare for seniors

(Overview of SGR Repeal, 2013)
Bringing Medicare Reimbursements into the 21st Century

The proposal, modeled after reimbursement systems employed widely in the private sector, improves upon Medicare’s outdated system by:

• Fully repealing the SGR and eliminating the estimated 25% across-the-board rate cut in 2014 and any future rate cuts called for under the SGR;

• Establishing a period of predictable, statutorily-defined payment rates, enabling physicians to prepare for and participate in payment reform;

• Empowering physicians to determine the quality and efficiency measures that are clinically meaningful for Medicare beneficiaries;

• Rewarding physicians who deliver high-quality and efficiency measures that are clinically meaningful for Medicare beneficiaries;

• Requiring CMS to provide timely feedback and data to physicians, enabling physicians to make adjustments to improve patient care and their assessed performance;

• Providing reimbursement options – instead of the current one-size fits all approach – that enable physicians to select the Medicare payment system that best fits their practice; and

• Engaging the physician community in efforts to improve, reform, and update Medicare’s outdated physician reimbursement system.

(Overview of SGR Repeal, 2013)

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Major Elements of Reform Proposal

• **Phase 1**—Repeal of SGR and provide a period of predictable, statutorily-defined payment rates:
  – Duration and size of payment rates will be set in statute.
  – This phase will provide physicians time to transition to, and play a prominent role in, reforming the Medicare FFS physician payment system.

(Overview of SGR Repeal, 2013)
Major Elements of Reform Proposal

• **Phase 2** – Reform Medicare’s FFS payment system. To better reflect quality of care provided:
  – Reform needed to maintain viable FFS system and emphasis on value mirrors many private payer efforts.
  – After period of stability, physician fee schedule updates will be based on performance on meaningful, physician-endorsed measures of care quality and participation in clinical improvement on quality over time.

*Overview of SGR Repeal, 2013*

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Major Elements of Reform Proposal

• **Phase 2 (cont.)** “Clinical improvement activities” (e.g., reporting clinical data to a registry or employing shared decision-making tools):
  – Medical specialty societies will develop meaningful quality measures and clinical improvement activities using a standard process
  – Performance based on both risk-adjusted relative rankings amongst physician specialty peer groups and improvement in quality over time
  – Physicians to be provided with timely access to quality performance score as well as with an appeals process to ensure accuracy

*Overview of SGR Repeal, 2013*
Major Elements of Reform Proposal

• Phase 2 (cont.):
  – Goal to reduce reporting burden on physician practices, override current ineffective CMS quality measurement programs, and align Medicare payment initiative with private payer initiatives.
  – Physicians who participate in certain alternative reimbursement models under Medicare may opt out of this modified FFS payment system.

(Overview of SGR Repeal, 2013)

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Major Elements of Reform Proposal

• Phase 3 – Further reform Medicare’s FFS payment system. To also account for efficiency of care provided:
  – After several years of risk-adjusted quality-based payments, physicians who perform well on quality measurement will be afforded opportunity to earn additional payments based on efficiency of care.
  – Physicians to be provided with timely access to efficiency performance score and an appeals process
  – Proposal will reduce reporting burden on physicians and align payment initiatives with private payer initiatives
  – Physicians who are participating in alternative reimbursement models under Medicare may opt out of this modified FFS payment system.

(Overview of SGR Repeal, 2013)
Assessment of Medicare Physicians Payment Options

- Providing information for further improvements:
  - An assessment of reformed FFS payment system and alternative Medicare and private sector delivery models will help ensure that physicians can select from payment system options
  - The Department of Health and Human Services will provide an annual report to Congress on the reformed FFS payment system and alternative model options that include recommendations
  - Congress will solicit recommendations from physician societies and other relevant stakeholders on how to further reform and improve Medicare’s physician payment system

(Overview of SGR Repeal, 2013)

Other Issues for Consideration

- Developing complementary reforms to improve the practice environment:
  - Medical liability reform
  - IPAB repeal
  - Private contracting/balance billing in Medicare without penalty to providers or patients to ensure patient choice and access
  - Gainsharing for improvements in quality and efficiency across defined patient populations

(Overview of SGR Repeal, 2013)
Hospital Reimbursement

**Hospital Readmissions Reduction Program** - The Affordable Care Act authorizes Medicare to reduce payments to acute care hospitals with excess readmissions that are paid under CMS's Inpatient Prospective Payment System (IPPS), beginning October 1, 2012. The program initially focuses on patients who were readmitted for selected high-cost or high-volume conditions, namely, heart attack, heart failure, and pneumonia.

High rates of readmission within 30-days of discharge from the hospitals may result from such factors as:
- Complications from treatments gotten during a hospital stay
- Inadequate treatment
- Inadequate care coordination and follow up care in the community
- Unexpected worsening of disease after discharge from the hospital

Hospital readmissions may cause undue suffering to patients and their families and may lead to significant increase in health care spending. [Get more information about Medicare’s Hospital Readmissions Reduction Program.](#)

**Hospital VBP Program** – Medicare now has information about how the quality of a hospital's care affects the payments it gets from Medicare. The Hospital VBP program, established by the Affordable Care Act, implements a pay-for-performance approach to the payment system that accounts for the largest share of Medicare spending – affecting payment for inpatient stays in approximately 3,000 hospitals across the country.

Under Hospital VBP, Medicare is adjusting a portion of payments to hospitals beginning in Fiscal Year (FY) 2013 based on either:
- How well they perform on each measure compared to all hospitals, or
- How much they improve their own performance on each measure compared to their performance during a prior baseline period.

The Hospital VBP program is designed to promote better clinical outcomes for hospitalized patients and improve their experience of care during hospital stays. [Get more information about the new Hospital VBP program.](#)
### H.R. 1470 – SGR Repeal & Medicare Provider Payment Modernization Act of 2015

**TOPIC:** Under current law: Under H.R. 1470 – 21.2% under SGR effective 04/01/15. Under SGR – future cuts could be over 25% for Physicians

<table>
<thead>
<tr>
<th>TOPIC: Pay for Performance and Quality Reporting Programs</th>
<th>Under current law:</th>
<th>Under H.R. 1470</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay for Performance and Quality Reporting Programs</td>
<td>- PQRs + MU + VBM Maximum Penalties:</td>
<td>Will have annual updates of:</td>
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<tr>
<td></td>
<td>2015 – 4.5%</td>
<td>• 0% 01/01-06/30/15</td>
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<tr>
<td></td>
<td>2016 – 6%</td>
<td>• 0.5% update for 07/15 thru 12/31/19</td>
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<tr>
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<td>2017 - 9%</td>
<td>• 0.0% un 2020 thru 2025</td>
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<tr>
<td></td>
<td>2018 - 10%+</td>
<td>• 2026 &amp; beyond - 1% for APM participants; 0.5% for all others</td>
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<tr>
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<td>2019 - 11%+</td>
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</tr>
<tr>
<td></td>
<td>2020 - 11%+</td>
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<tr>
<td></td>
<td>Includes PQRs; MU; VBM</td>
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Physician FFS annual update

(H.R. 1470 - SGR Repeal,” 2015)
### H.R. 1470 – SGR Repeal & Medicare Provider Payment Modernization Act of 2015

#### TOPIC: FUNDING FOR QUALITY MEASURE DEVELOPMENT

<table>
<thead>
<tr>
<th>UNDER CURRENT LAW</th>
<th>UNDER H.R. 1470</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE.</td>
<td>$15 million/year for 2015-2019 for development of measures – a total of $75 million. Excess available thru 2022</td>
</tr>
</tbody>
</table>

#### TOPIC: ACCESS TO DATA BY PHYSICIANS

<table>
<thead>
<tr>
<th>UNDER CURRENT LAW</th>
<th>UNDER H.R. 1470</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data provided by thru physician feedback program by CMS - with no requirements for timeliness.</td>
<td>CMS required to provide timely feedback reports at individual physician level (i.e. quarterly)</td>
</tr>
</tbody>
</table>

#### TOPIC: CLAIMS DATA

<table>
<thead>
<tr>
<th>UNDER CURRENT LAW</th>
<th>UNDER H.R. 1470</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician 2012 claims data released by CMS – Qualified Entities (QEs) authorized to do public reports from data.</td>
<td>Provides for an annual release of physician data with no explicit safeguards. Expands QE authority to provide non-public reports and data with specific protections. Also provides data to QCDRs.</td>
</tr>
</tbody>
</table>

(*“H.R. 1470 - SGR Repeal,” 2015*)

### H.R. 1470 – SGR Repeal & Medicare Provider Payment Modernization Act of 2015

#### TOPIC: STANDARD OF CARE PROTECTION ACT

<table>
<thead>
<tr>
<th>UNDER CURRENT LAW</th>
<th>UNDER H.R. 1470</th>
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</thead>
<tbody>
<tr>
<td>NONE.</td>
<td>Included in bill. Quality program standards do not set standard of care in medical liability actions.</td>
</tr>
</tbody>
</table>

#### TOPIC: PHYSICIANS OPTING OUT OF MEDICARE

<table>
<thead>
<tr>
<th>UNDER CURRENT LAW</th>
<th>UNDER H.R. 1470</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must renew status every 2 years or face serious consequences</td>
<td>Status continues indefinitely – no need to review every 2 years.</td>
</tr>
</tbody>
</table>

#### TOPIC: CHRONIC CARE MANAGEMENT SERVICES (CCM)

<table>
<thead>
<tr>
<th>UNDER CURRENT LAW</th>
<th>UNDER H.R. 1470</th>
</tr>
</thead>
<tbody>
<tr>
<td>Although CMS started paying CCM in 2015, they could discontinue payment for these services in the future.</td>
<td>Bill requires CMS to permanently pay for care management for patients with chronic health conditions. Does not require an annual wellness visit or initial preventive physical examination.</td>
</tr>
</tbody>
</table>

(*“H.R. 1470 - SGR Repeal,” 2015*)
**H.R. 1470**

- The last reporting period for PQRS, MU and VBM – 2018.
- Physicians to be judged by what is relevant to their practice
- Physicians can get credit for improvements and for hitting performance target.
  - Would know those targets at start of each reporting period
  - Would receive more timely individual feedback
- MIPS scores to include 4 factors:
  - Quality (PQRS/30%)
  - Resource use (VBM/30%)
  - MU (25%)
  - Clinical practice improvement activities (15%)
- These percentages can be adjusted for individual physicians or group practices.

("H.R. 1470 - SGR Repeal," 2015)
The Key to Transitioning from Fee-for-Service to Value-Based Reimbursement

“Transitioning to Value-based Payments

• The transition from the fee-for-service (FFS) reimbursement system to one based on value is one of the greatest financial challenges health systems currently face. This challenge is so big that we will only address of few of its aspects here.

Reconciling Value-Based Payments in a Fee-for-Service Environment

• Value-based payment contracts are in their infancy, and most are structured according to a shared savings model. Shared savings arrangements differ, but in general they incentivize providers to reduce spending for a defined patient population by offering them a percentage of any net savings they realize. The Medicare Shared Savings Program is the most well-known and standardized example of this new model.

(Brown & Crapo, n.d.)

The Key to Transitioning from Fee-for-Service to Value-Based Reimbursement

Tracking performance in this kind of arrangement is a significant challenge for health systems because it requires keeping track of two very different payment systems simultaneously. Medicare continues to reimburse health systems on a FFS basis; then, at the end of the year, shared savings bonuses are calculated. Medicare benchmarks each provider against the rate of increase for the overall FFS population. If a hospital did better than that the FFS population, they get a piece of the savings. Hospitals must operate in the FFS world while attempting to anticipate this value-based bonus.

Tracking shared savings reimbursements that come in at the end of the year requires health systems to be much more sophisticated in their accounting capabilities than most are today. It simply won’t work to account for all payers and all patients in the same way. A hospital has to know every patient in the accountable care organization (ACO), what services they’re getting, and what it costs. An ACO environment requires considering questions like: for each defined population of patients, what was our financial performance and how did it compare to the contract? The ability to measure performance at this level of granularity will require much more sophisticated IT capabilities than most health systems now have.”

(Brown & Crapo, n.d.)
FACT SHEET
APRIL 2015

TWO-STEP ATTRIBUTION FOR MEASURES INCLUDED IN THE VALUE MODIFIER

Overview

The Value-Based Payment Modifier Program evaluates the performance of solo practitioners and groups of practitioners, as identified by their Taxpayer Identification Number (TIN), on the quality and cost of care they provide to their Fee-for-Service Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) disseminates this information to TINs in confidential Quality and Resource Use Reports (QRURs). For each TIN subject to the Value Modifier, CMS also uses these data to calculate a Value Modifier that adjusts the TIN’s physicians’ Medicare Physician Fee Schedule payments upward, downward, or not at all, based on the TIN’s performance.

In assessing performance on several of the quality and cost measures included in the QRUR and Value Modifier, CMS uses a two-step attribution process to associate beneficiaries with TINs during the year performance is assessed. This process assigns a beneficiary to the TIN providing more primary care services to that beneficiary than any other TIN. The attribution methodology determines which beneficiaries are included in the calculation of each TIN’s quality and cost performance and payment adjustment under the Value Modifier.

How does two-step attribution work?

The two-step attribution process. Beneficiaries who do not receive any primary care service from a physician during the performance period are not attributed to any TIN. CMS attributes beneficiaries to TINs¹ according to the following two-step process:

Step 1: A beneficiary is attributed to a TIN if the TIN’s primary care physicians (PCPs)—defined as family practice, internal medicine, geriatric medicine, or general practice physicians—accounted for a larger share of allowed charges for primary care services for the beneficiary than PCPs of any other TIN. Primary care services include evaluation and management services provided in office and other non-inpatient and non-emergency-room settings, as well as initial Medicare visits and annual wellness visits.² If two TINs tie for the largest share of a beneficiary’s primary care services, the beneficiary is assigned to the TIN that provided primary care services most recently.

¹ CMS also attributes beneficiaries to Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals that are not subject to the Value Modifier.

² Please refer to Table 1 for a list of PCPs considered in the first step of the attribution process. Table 2 lists the Healthcare Common Procedure Coding System (HCPCS) codes that identify primary care services.
Step 2: Beneficiaries who are not assigned to a TIN after the first step (because they did not receive any eligible primary care services from a PCP) and received at least one primary care service from a physician, regardless of specialty, are assigned to the TIN whose physician specialists, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) accounted for more Medicare allowed charges for primary care services than any other TIN.³

Measures Included. Two-step attribution is implemented for the following claims-based measures included in the QRUR and Value Modifier: Acute and Chronic Ambulatory Care-Sensitive Condition (ACSC) Composite, 30-day All-Cause Hospital Readmission, Per Capita Costs for All Attributed Beneficiaries, and Per Capita Costs for Beneficiaries with Specific Conditions measures.⁴,⁵

Beneficiaries excluded from attribution. Attribution for the measures listed above excludes beneficiaries who:

- were enrolled in Medicare Part A only or Medicare Part B only for any month during the year
- were enrolled in Medicare managed care (for example, a Medicare Advantage plan) for any month during the year
- resided outside of the United States, its territories, and its possessions for any month during the year

Beneficiaries excluded from the attribution process are not considered for inclusion in the calculation of the claims-based quality and cost measures.
Tips, Tools, and Techniques

1. Important to become aware of future reimbursement methodologies to prepare you practice or clinic. The opportunities are encouraging.

2. Start with an analysis of current reimbursement, costs of providing your services, and opportunities for improving efficiency.

3. Begin preparation now for providing input when requested on future reimbursement and providing for alternative ways to achieve efficiency in clinical care and provisions of services to achieve the opportunity for additional bonuses for "exceptional performance."

References


Questions?

• Maxine Collins
• mcollins@pmimd.com

Thank you for your attendance!

Get your questions answered on PMI’s Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp