Legislative Update
Wipfli CAH/RHC Conference

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Overview

- NARHC Washington Update
- MACRA Overview and Update

American Health Care Act
What Happened?

- Bill failed to pass the House
- Proponents:
  - President Trump
  - Speaker Ryan
  - Secretary Price
  - ~200 Congressional Republicans
- Opponents:
  - Democrats
  - Freedom Caucus Republicans
  - Tuesday Group Republicans

American Health Care Act
What did it do?

- Repealed aspects of the Affordable Care Act related to taxing and spending
- Promoted low premium high deductible plans with health savings accounts (HSAs)
- Replaced ACA subsidies with tax credits based on age
- Sunset Medicaid expansion enhanced FMAP rate
- Placed State Medicaid Programs on a Per-capita budget.

American Health Care Act
Why do RHCs care?

- Per-capita allotment gave states a strong incentive to stay under budget
- The CBO estimates that the federal government would have saved $880 billion over ten years
- Would states feel a budget squeeze and seek to reduce RHC Medicaid payments?
- Federal mandate establishes the Medicaid payment rate for RHCs

FY 2015 Spending on Medicaid in Minnesota	
Rural Health Clinics	$18,209,870
Total	$10,704,500,992
RHC payments as percent of total	0.17%

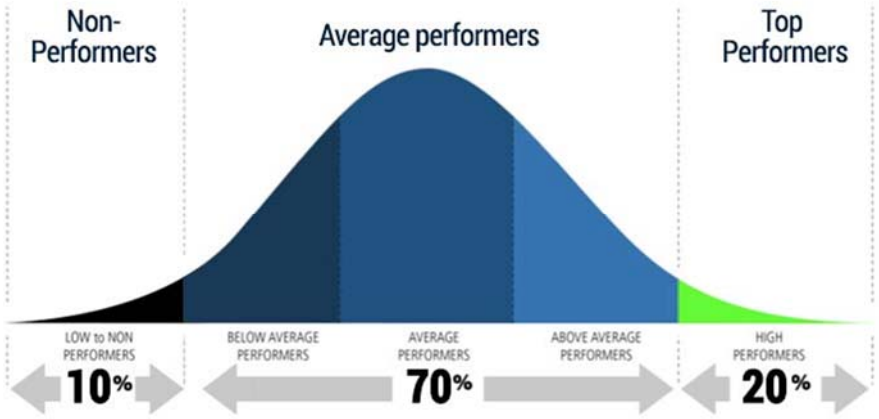
American Health Care Act What is next?

- Health care is stalled for now
  - Anyone's guess as to when they try it again
- Aspects of AHCA might be included in other legislative items
  - Per capita allotment might be included in tax reform
- Regulatory actions are more significant in the near term
  - What will Tom Price and Seema Verma want to do?

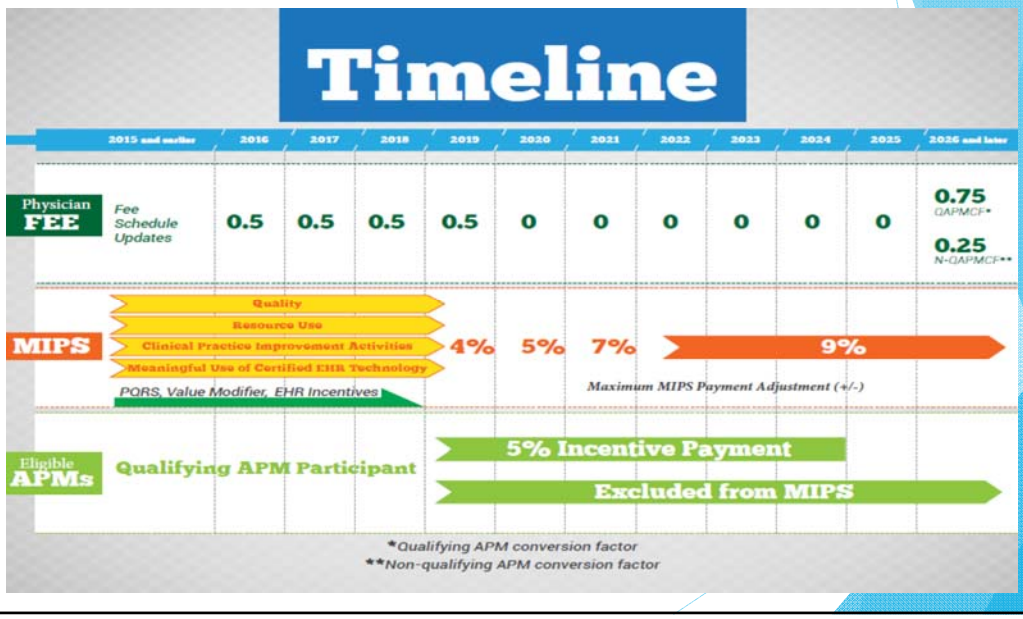
Medicare Access and CHIP Re-Authorization Act - Basics

- The main piece of legislation driving payment reform in healthcare
- Basics:
  - Repeals Sustainable Growth Rate Formula
  - Offers two tracks for reimbursement instead of Physician Fee Schedule
    - 1-Merit Based Incentive Payment System
    - 2-Alternative Payment Models
  - Many RHCs will qualify for low-volume exception
  - RHCs may voluntarily report
  - Likely to be used by other payers
- www.Qpp.cms.gov

MIPS (Merit Based Incentive Payment System) – What is that?



MACRA - Timeline



Composite Performance Score Categories

Category	Year 1 - 2017 Reporting, 2019 Reimbursement	Year 2 - 2018 Reporting, 2020 Reimbursement	Year 3 - 2019 Reporting, 2021 Reimbursement
Quality	60%	45%	30%
Clinical Performance Improvement Activities	15%	15%	15%
Advancing Care Initiative Practices	25%	25%	25%
Resource Use	0%	15%	30%

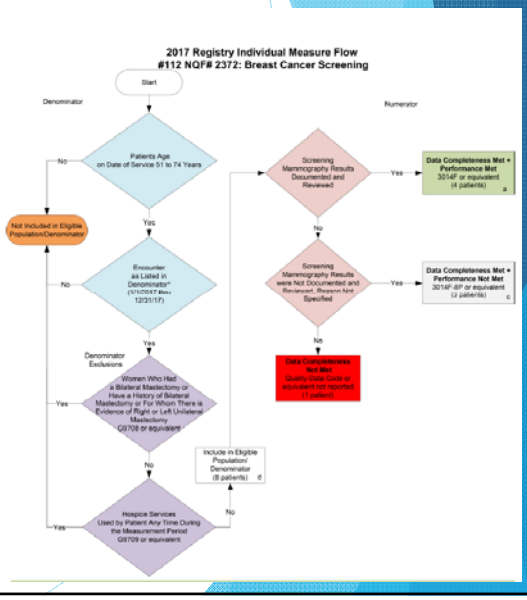
Quality

- Similar to PQRS, except **what** an Eligible Clinician reports matters now.
- Eligible Clinicians generally must report on at least 6 measures of their choosing.
- Different rules if you report as an individual or as a practice.
- Multiple exceptions provided (Ex. groups with 15 or more must report All Cause Re-Admission measure)
- Most measures are currently process measures, CMS wants to move more and more towards “outcomes” measures
- Clinicians will receive a score between 1-10 depending on how they do compared to their peers.

Quality Measure Example – Breast Cancer Screening

- Percentage of women 50 through 74 who had a mammogram to screen for breast cancer within 27 months.
- Not just Medicare population
- Process Measure

Breast Cancer Screening Workflows



Quality Measure Example – Breast Cancer Screening

Measure_Name	Submission_Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Breast Cancer Screening	Claims	38.46 - 48.01	48.02 - 55.67	55.68 - 62.78	62.79 - 69.41	69.42 - 77.18	77.19 - 87.87	87.88 - 98.52	>= 98.53
Breast Cancer Screening	EHR	12.41 - 22.21	22.22 - 32.30	32.31 - 40.86	40.87 - 47.91	47.92 - 55.25	55.26 - 63.06	63.07 - 73.22	>= 73.23
Breast Cancer Screening	Registry/QCDR	14.49 - 24.52	24.53 - 35.70	35.71 - 46.01	46.02 - 55.06	55.07 - 63.67	63.68 - 74.06	74.07 - 87.92	>= 87.93

Performance Rate dictates what decile you fall in and what your score will be on the measure 1-10

Quality Measure Example – Use of imaging studies for low back pain

Measure_Name	Submission_Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Use of Imaging Studies for Low Back Pain	EHR	83.12 - 90.47	90.48 - 96.14	96.15 - 99.99	--	--	--	--	100
Use of Imaging Studies for Low Back Pain	Registry/QCDR	55.00 - 91.99	92.00 - 99.99	--	--	--	--	--	100

Example of a "Topped-out" measure, impossible to get a full 10 points if you report this measure

Quality Measure Example – Hypertension Improvement in blood pressure

Measure_Name	Submission_Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Hypertension: Improvement in Blood Pressure	EHR	6.82 - 9.31	9.32 - 11.70	11.71 - 14.40	14.41 - 17.39	17.40 - 21.44	21.45 - 27.61	27.62 - 39.04	>= 39.05
Hypertension: Improvement in Blood Pressure	Registry/QCDR	2.39 - 2.93	2.94 - 3.46	3.47 - 3.92	3.93 - 4.71	4.72 - 5.53	5.54 - 6.74	6.75 - 9.99	>= 10

Example of an outcomes measure

Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.

Resource Use Measures

- Measures surrounding cost
- Similar to the Value Modifier Program
  - Total per capita cost measure
  - Medicare Spending Per Beneficiary measure
  - Episode-based measures
- No reporting required, gathered from claims information
- Will not matter in year 1 (Transitional Year)

Clinical Performance Improvement Activities

- Not compared against others, you get a certain amount of points for meeting the CPIA requirement.
- 10 point activities and 20 point activities, everyone needs 40 points to get full credit for CPIA…They double the point value for groups with 15 or fewer clinicians or clinicians located in HPSA or rural area…
- Binary
- Everyone should do well on CPIA section
- Examples of CPIAs:
  - Expanded practice access (hours), participating in Transforming Clinical Practice Initiative
  - Seeing Medicaid patients in a timely manner (undefined document in Medical Record)
  - Participating in a RHC involved in "ongoing engagement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality improvement and benchmarking improvement which will ultimately benefit patients."
- Where to find the full list of improvement activities? Table H in the final rule: https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf

Advancing Care Information

- The EHR component of the CPS score (successor to MU)
- Scored via a "base score" + a "performance score"

- Base score worth 50 points
- Performance score worth up to 90 points
- All you need is 100 points total to get the top score on this section…

Advancing Care Information

TABLE 6: Base Score Primary Proposal Advancing Care Information Objective and Measure Reporting*

	Objective	Measure*	Total Base Score
1	Protect Patient Health Information	Security Risk Analysis	50 %
2	Electronic Prescribing	ePrescribing	
3	Patient Electronic Access	Patient Access	
		Patient-Specific Education	
4	Coordination of Care Through Patient Engagement	View, Download or Transmit (VDT)	
		Secure Messaging	
		Patient-Generated Health Data	
5	Health Information Exchange	Patient Care Record Exchange	
		Request/Accept Patient Care Record	
		Clinical Information Reconciliation	
6	Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	
		(Optional) Syndromic Surveillance Reporting	
		(Optional) Electronic Case Reporting	
		(Optional) Public Health Registry Reporting	
		(Optional) Clinical Data Registry Reporting	

Advancing Care Information Performance – Base Score Example

- Protect Patient Health Information
  - Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1)…
- To meet this measure, eligible clinicians must attest YES to conducting or reviewing a security risk analysis and implementing security updates as necessary and correcting identified security deficiencies.
- Binary

Advancing Care Information – Performance Score

TABLE 9: Sample Performance Score

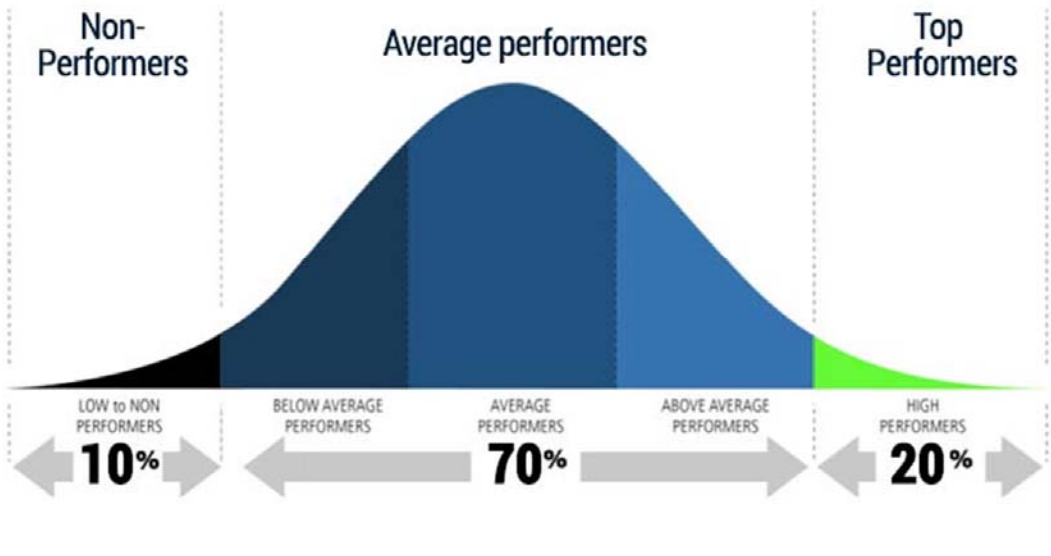
Objectives	Patient Electronic Access		Coordination of Care Through Patient Engagement			Health Information Exchange (HIE)		
Measures	Patient Access	Patient-Specific Education	VDT	Secure Messaging	Patient-Generated health Data	Patient Care Record Exchange	Request/ Accept Patient Care Record	Clinical Information Reconciliation
Performance Rate Score	95%							
		65%						57%
			33%	31%			38%	
					25%	21%		
Percentage Points Earned	9.5%	6.5%	3.3%	3.1%	2.5%	2.1%	3.8%	5.7%
Performance Score = 36.5 percent								

Advancing Care Information – Performance Score Example

- Provide Patient Access
  - NUMERATOR: The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured meet the technical specifications of the API in the MIPS eligible clinician's CEHRT.
  - DENOMINATOR: The number of unique patients seen by the MIPS eligible clinician during the performance period.
- Performance Based
- You can find all ACIP measure specifications on www.QPP.CMS.gov

Calculating Composite Performance Score

Category	Score	Year 1 Weight	Weighted Score
Quality Performance Category	75	60%	45
Resource Use Performance Category	60	0%	0
Clinical Performance Improvement Activities Performance Category	100	15%	15
Advancing Care Information Performance Category	80	25%	20
Composite Performance Score (CPS)	N/A	N/A	**80**



MIPS - Does it Apply to RHCs?

- Mostly no – will not affect AIR
- MIPS includes a low volume exception – many RHCs should qualify
- Low-volume exception finalized as:
  - Less than $30,000 of Part B charges **OR** provides care to fewer than 100 Part B-enrolled Medicare beneficiaries
  - If you don't qualify for an exception…MIPS adjustments will only apply to those claims submitted on the 1500.
- Could it affect RHCs in the future?
  - Yes
  - Other payers could start utilizing CPS scores for their purposes
  - Quality is coming to the RHC program but it is unclear how

MIPS RHC Voluntary Reporting

- CMS is allowing RHCs to voluntarily report
  - Will have no bearing on RHC AIR
  - May allow RHCs to test waters and transition to traditional office
  - NARHC is warning CMS not to generalize the scores that are reported
  - Unclear if all the moving parts of the MIPS CPS would translate well to RHC billing on the UB-04

Pick your Pace and Transitional Year Policies

- Option 1: "test the quality payment program"
  - Submit some data and avoid a negative payment adjustment
- Option 2: Participate for part of the calendar year
  - Smaller positive/negative adjustment
- Option 3 Participate for full calendar year
  - As initially designed, would be eligible for full 4% adjustment up or down
- Option 4 Participate in Advanced APM

- CMS under Obama Administration leadership decided to blunt the penalties in the program via creating a "transitional" year.
- How committed will the Trump Administration be to implementing all of MACRA ~ including penalties? Will the provider community welcome full implementation or push to eliminate provider-risk? We will find out this summer…

APMs – What are They?

- Difference between APMs (term thrown around a lot) and Advanced APMs for the purposes of MACRA
- Harder to describe because the models vary.
  - If a certain amount of physician revenue is attributable through an Advanced APM, then that physician qualifies for certain incentives
- To be an Advanced APM the model must:
  - Require participants to use certified EHR
  - Provide payment for services based on quality measures in MIPS
  - Providers must bear "more than nominal" amount of risk for monetary losses.
- Important to note that one of the main incentives to join an advanced APMs involves a lump sum payment of 5% to providers. However, RHC services (because they are not reimbursed under the PFS) would not be included in the amount upon which the APM incentive payment is based.

How to Qualify for incentive payments in APM?

Year	2019	2020	2021	2022	2023	2024
Percent of revenue through advanced APM entity	25%	25%	50%	50%	75%	75%

APMs, advanced APMs and RHCs

- To be clear, RHC's CAN participate in APMs and advanced APMs
- Any RHC joining an APM would do so not because of some formal government incentive payment, but rather because the APM itself offers value to the RHC
- Still very early on in the development of advanced APMs
- Only Advanced APMs proposed are:
  - Comprehensive ESRD Care (CEC) (LDO Arrangement)
  - Comprehensive Primary Care Plus [in a model/testing phase…RHCs excluded from participating]
  - Medicare Shared Savings Program Track 2 and 3
  - Next Generation ACO Model
  - Oncology Care Model two-sided risk arrangements

Trump Executive Orders

- President Trump issued a presidential memorandum (technically not an E.O.) on his first day in office suspending all pending regulation.
- It is unclear if things that were finalized but not yet enforced/implemented will be affected
  - Emergency Preparedness rule "effective" Nov 2016, "implemented" Nov 2017

Trump Executive Orders

- **Minimizing the economic burden of the ACA**
  - "…shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications."
  - Nondiscrimination rules are a part of the ACA
- **Reducing regulation and controlling regulatory costs**
  - Plus 1, minus 2
  - Cost of new regulatory burden for FY 2017 must be zero
  - Emergency Preparedness estimated cost of compliance for RHCs is just over $6,000

Questions?

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