Mid-Atlantic Telehealth Resource Center

UNDERSTANDING & ALIGNING TELEHEALTH WITH MEDICARE PAYMENT REFORM & QUALITY MEASURES

MATRC 2017 Telehealth Summit

Jonathan Joseph, JD
Christian & Barton LLP

Cybil Roehrenbeck, JD
Polsinelli PC

Karen Meador, MD
BDO

PROBLEMS WITH THE SUSTAINABLE GROWTH RATE (SGR) PROMPTED POLICY MAKERS TO SEEK A SOLUTION

- As part of the Balanced Budget Act of 1997, the SGR was intended to limit Medicare fee for service payments to a budgeted amount through a formula based on an estimate of the:
  - percentage change in physician service fees
  - percentage change in the average number of Medicare FFS beneficiaries
  - 10-year average annual percentage change in real GDP
  - percentage change in expenditures due to laws or regulations
- For the first few years of SGR, doctors received modest increases
- In 2002, doctors faced a 4.8% pay cut
- Every year since 2002, Congress has passed legislation to temporarily defer pay cuts

TOO MANY PAYMENT PATCHES UNDER SGR

Law	Cut Year	Score (bil.)
PL 108-7	2003	$54.0
PL 108-173	2004, 2005	$0.2
PL 109-171	2006	-$0.4
PL 109-432	2007	$3.1
PL 110-173	2008 (6 mos)	$6.4
PL 110-276	2008 (6 mos), 2009	$9.4
PL 111-118	2010 (2 mos)	$2.0
PL 111-144	2010 (1 mo)	$1.0
PL 111-157	2010 (2 mos)	$2.0

Law	Cut Year	Score (bil.)
PL 111-192	2010 (6 mos)	$6.0
PL 111-286	2010 (1 mo)	$1.0
PL 111-309	2011	$14.9
PL 112-78	2012 (2 mos)	$3.6
PL 112-96	2012 (10 mos)	$18.0
PL 112-240	2013	$25.2
PL 113-67	Jan-Mar 2014	$7.3
P.L. 113-93	Apr 2014-Mar 2015	$15.8
Total Cost		$169.5

Source: Congressional Budget Office 2015

MACRA - Medicare Access & CHIP Reauthorization Act of 2015

- Largest healthcare law since Affordable Care Act
- Permanently repeals Sustainable Growth Rate (SGR)
- Sets Medicare Part B fee schedule adjustments for next 10+ years

2016-2019	0.5% annual increase
2020-2025	0% annual increase
2026 +	0.25% annual increase for Merit-Based Incentive Payment System *OR* 0.75% increase for Advanced Alternative Payment Model

- Creates Quality Payment Program (QPP)
  - *Additional payment adjustments based on QPP go into effect 2019 with 2017 being the first performance year*

TWO NEW PAYMENT TRACKS CREATED BY MACRA

- **Merit-Based Incentive Payment System (MIPS)**

PQRS
VBPM
MU

- **Advanced Alternative Payment Models (Advanced APM)**
  - Requires “significant” share of revenue in contracts with two-sided risk, quality measurement and EHR requirements.

THE MACRA FINAL RULE WAS RELEASED OCTOBER 14, 2016

- **Compared with the Proposed Rule:**
  - Instead of a full year of reporting being required in 2017, very limited participation in MIPS will allow the penalty to be avoided in 2019.
  - Six instead of nine Quality metrics will need to be reported.
  - Four instead of eighteen Advancing Care Information metrics will need to be reported.
  - Four medium weighted or two high weighted Improvement Activities instead of six or three, respectively, with additional relief for small and rural or health shortage area practices.
  - The Cost category has been reweighted to 0% (from 10%) for 2017 (while the weighting of the Quality category has gone up from 50% to 60%.)
  - All physicians participating in Medicare will receive a 0.5% update for services provided in 2017.
  - The final rule simplifies the financial risk criteria for Advanced APMs. CMS anticipates exploring a new Advanced APM in 2018, called “ACO Track 1+,” which will require lower levels of risk than other accountable care organizations (ACO).

MACRA'S IMPACT ACROSS PROVIDERS

Who is Included and Who is Exempt

- **Included:**
  - Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurses, Anesthetists
  - Medical groups that include any of the aforementioned clinicians
  - Medicare Part B payments

- **Exempt:**
  - Clinicians or groups that fall under low volume threshold (less than $30,000 in allowed Medicare charges OR 100 or fewer Medicare Part B patients)
  - Providers in their first year of Medicare billing
  - Clinicians billing under RHC or FQHC payment methodologies
  - Medicare Part A

YOUR OPTIONS FOR 2017 TO AVOID PAYMENT PENALTY IN 2019

- **MIPS**
  - **Test** the Quality Payment Program by submitting one quality measure or one improvement activity or the required ACI measures on at least one occasion.
  - **Partially Participate** as above for at least 90 days and become eligible for positive adjustment of less than 4%.
  - **Fully Participate** for the Full Calendar Year: Meet all reporting requirements and become eligible for the maximum positive adjustment.

- **Advanced APM**
  - If you receive 25% of Medicare Part B payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.

Source: https://apps.ama-assn.org/pme/#/education/mips

FINAL RULE MIPS REQUIREMENTS FOR 2017

Quality	Report on 6 quality measures, including an outcome measure for 90 days.
Advancing Care Information	Report 4 ACI required measures for 90 days.
Improvement Activities	Groups with </= 15 participants or those in a rural or health professional shortage area report 2 activities (or 1 high weighted) for 90 days. Others report 4 activities (or 2 high weighted) for 90 days. Special treatment for APM and medical homes.
Cost	No data submission requirement as this category score is calculated from claims.

Source: https://qpp.cms.gov/measures/performance

FINAL RULE MIPS REQUIREMENTS FOR 2017

Quality

https://qpp.cms.gov/measures/quality

- Clinicians will report 6 measures, one which must be an outcome
- Measures are chosen from six quality domains:
  - person-centered care
  - care coordination
  - patient safety
  - effective clinical care (outcomes)
  - efficient care
  - population health
- Available measures to select from will be updated annually and published by November 1.
- 1 to 10 points are assigned for each measure based on a benchmark.
- Some groups in MIPS APMs qualify for special scoring such as those in Shared Savings Track 1 or the Oncology Care Model.

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf

FINAL RULE MIPS REQUIREMENTS FOR 2017

Advancing Care Information

https://qpp.cms.gov/measures/aci

- A base score is calculated from
  - Protect patient health information
  - e-Prescribing
  - Provide electronic patient access
  - Health information exchange
- The 4 measures are to be reported for 90 days.
- There are two options for reporting based on your EHR type.

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf

FINAL RULE MIPS REQUIREMENTS FOR 2017

Improvement Activities

https://qpp.cms.gov/measures/ia

- Clinicians report 4 medium weight or 2 high weight activities.
- For practices of 15 or fewer or those in rural of professional shortage areas, only 2 medium weight or 1 high weight activity is required.
- Those participating in a MIPS APM automatically get 50% of maximum score and can increase to the maximum with other activities.
- Those in a certified medical home will receive the maximum score automatically.

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf

FINAL RULE MIPS REQUIREMENTS FOR 2017

Cost

- This category will be calculated from claims in 2017 but will not be used until 2018 to contribute to payment calculation in 2020.

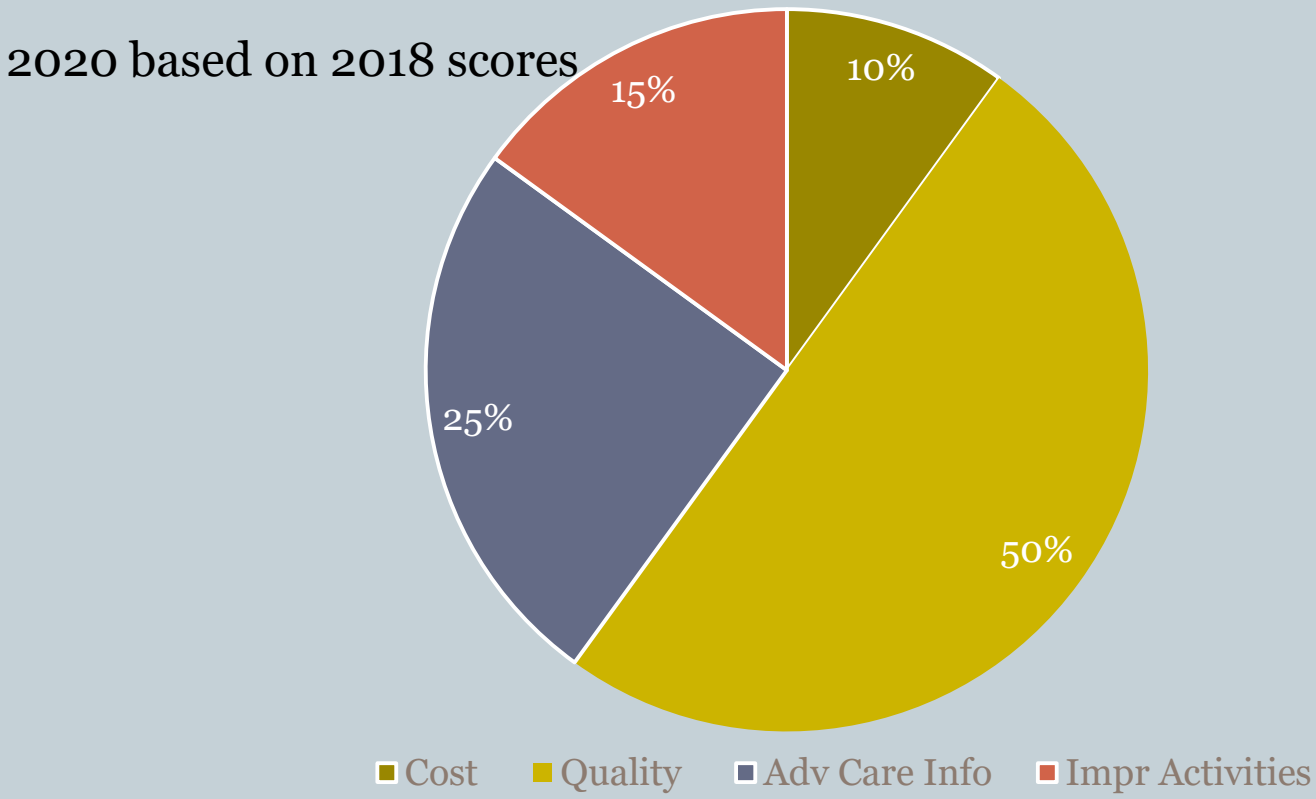
Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf

MIPS Reporting for ACO Track 1

MIPS Category	Weight	Reporting Requirements	Reporting Levels and Performance
Quality	50%	Report GPRO quality measures required for the ACO	Reported at the ACO level and overall performance applies to all physicians and other eligible clinicians within the ACO
Advancing Care Information	30%	Two options for reporting: 1. Report four Stage 2-equivalent measures 2. Report five Stage 3-equivalent measures	Reported at the TIN level for all TINs within the ACO; weighted average of each TIN's performance used for the MIPS composite score
Clinical Practice Improvement Activities	20%	*No reporting required; receive automatic full 20% due to ACO participation*	*Not applicable*
Cost	0%	*Not applicable in 2017*	

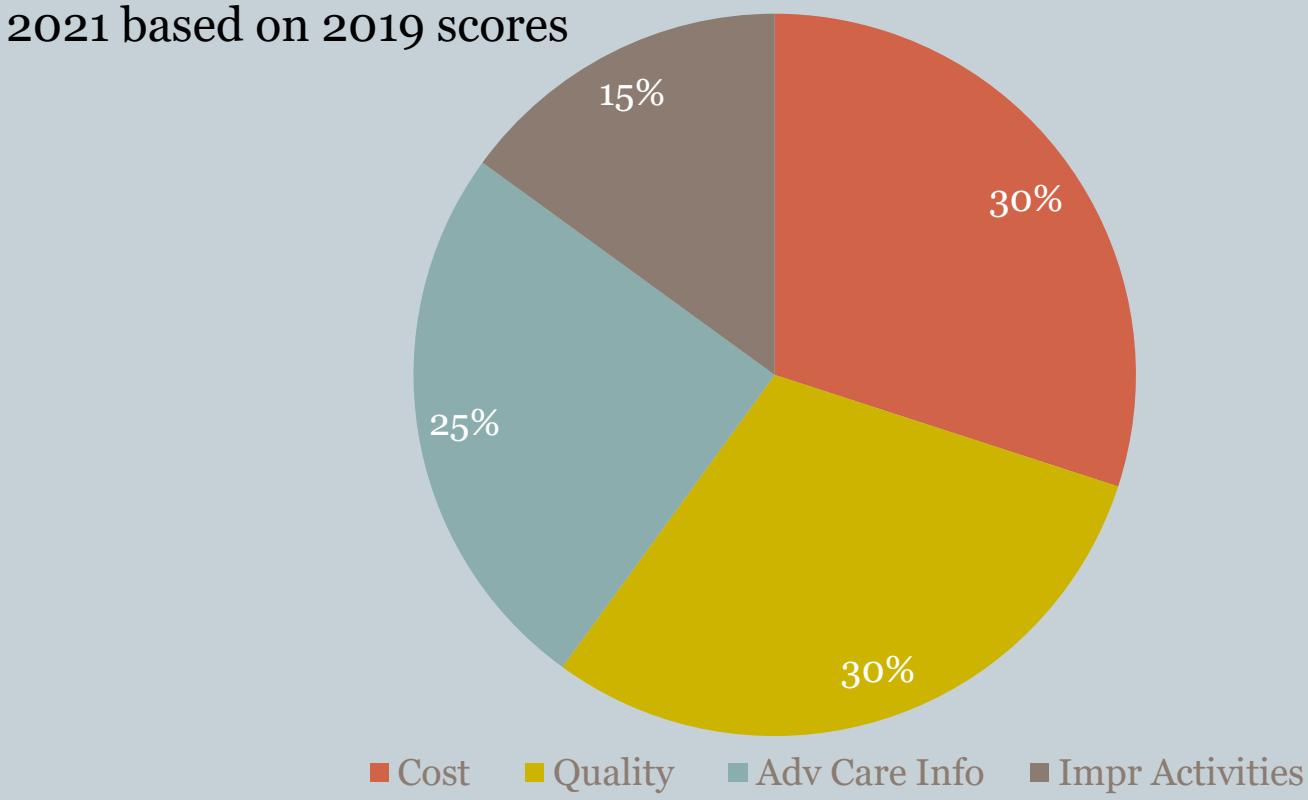
Under the new scoring system, a single MIPS composite performance score will be generated based on an assessment of performance in the four different categories

Over time the cost weighting increases as the quality weighting decreases



Under the new scoring system, a single MIPS composite performance score will be generated based on an assessment of performance in the four different categories

Over time the cost weighting increases as the quality weighting decreases



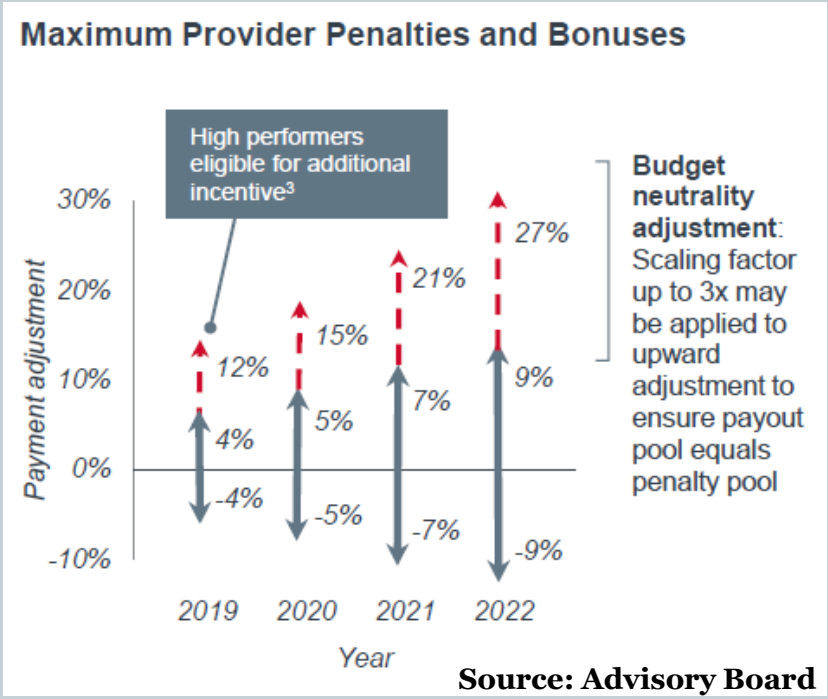
MIPS TRACK: THE COMPOSITE SCORE

- **Total possible points of 100**
  - The threshold will be 3 for 2017, meaning that a score of 3 or higher will avoid the penalty in 2019
  - CMS estimates that 90% of eligible clinicians will receive neutral or positive payment adjustments in 2019
  - Eligible clinicians who score 70 or higher will be eligible for a portion of the "exceptional payment adjustment" funded from a pool of $500M.

MIPS: A ZERO-SUM GAME FOR CLINICIANS

Stronger Performers Benefit at Expense of Those with Low Scoring/No Data

- **Payment Adjustment Determination**
  1. Providers assigned score of 0-100 based on performance across four categories
  2. Provider score compared to CMS-set annual Performance Threshold (PT); non-reporting groups given lowest score
  3. Providers scoring above PT receive bonus; providers scoring below PT subject to penalty



Exceptional performance bonus: Those scoring in top 25% eligible for an additional annual performance adjustment of up to 10%, 2019-25 (This part of the arrangement is not budget neutral)

Only “Advanced” APMs qualify for full MIPS exemption , and these APMs must meet certain criteria

As defined by MACRA, advanced APMs must meet the following criteria:

The APM requires participants to use certified EHR technology.

The APM bases payment on quality measures comparable to those in the MIPS quality performance category.

The APM is construed more narrowly than expected. The regulation: (1) requires APM’s to bear more than nominal financial risk for monetary losses; or (2) is a Medical Home Model expanded under CMMI

ADVANCED APMS

Currently include:

- **Next Generation ACO Model**
- **Shared Savings Program** (Tracks 2 and 3)
- C**omprehensive ESRD Care (CEC)** (large dialysis organization arrangement)
- C**omprehensive Primary Care Plus (CPC+)**
- **Oncology Care Model (OCM)** (the two-sided risk track available in 2018)

Advanced APM track participants will be exempt from MIPS payment adjustments, will qualify for a 5 percent per annum Medicare Part B incentive payment in 2019-2024, and will receive a higher fee schedule update for 2026 and beyond.

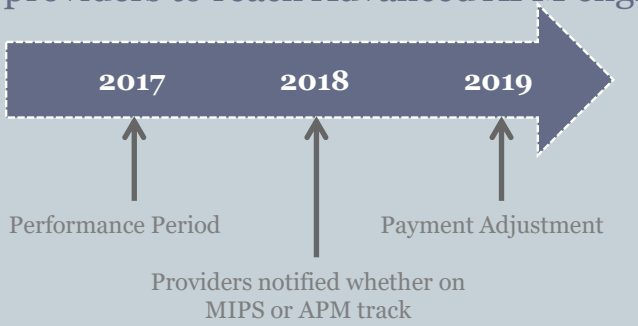
KEY CONSIDERATIONS FOR MIPS TRACK

- Timeline: Payment Adjustment is operated on a two-year Look-Back Policy
  - Payment adjustment in 2019 is determined based on quality reporting measures in 2017

- Public Reporting Data: Physician Compare
  - Website includes information about providers who participate in CMS quality programs (Quality Program Participation Indicators), as well as Quality Measures
  - Continued phase-in of quality measures that will be reported
- Individual versus Group Reporting
  - Clinicians can choose whether to report individually or as a group (Those in Advanced APM must report as a group)
- Data Submission Requirements
  - Those clinicians choosing to report as individuals will use a combination of their billing Taxpayer Identification Number (TIN) and National Provider Identifier (NPI) to report and assess their performance.
  - Those clinicians reporting as a group would use their group's billing TIN.
  - Clinicians who participate in a non-qualified APM must report through MIPS using a unique APM participant identifier that combines the four identifiers: APM identifier, APM entity identifier, TIN(s), eligible professional NPI

KEY CONSIDERATIONS FOR ADVANCED APM TRACK

Timeline: Not much time for most providers to reach Advanced APM eligibility by 2019



Participants will be notified of Qualifying Participant (QP) or Partial Qualifying Participant (PQP) eligibility no sooner than 6 months after performance

- If PQP, eligible professionals will have little time to participate in MIPS so may consider submitting for MIPS while APM is under review

Non-advanced APMs or advanced APMs that do not meet QP thresholds receive preferential scoring – MIPS APM Scoring Standard

- Cost /Resource Use not scored
- Automatic 50% of maximum score for Improvement Activities
- May be eligible for special Quality scoring
- $500 million pool of incentives available for MIPS eligible professionals who achieve "exceptional performance"

STEPS TO PREPARE FOR MACRA IMPLEMENTATION

- Ensure successful participation in existing quality reporting programs or identify gaps to close
  - MACRA is designed to expand upon these programs (PQRS, VBPM, EHR)
- Prepare your organization for new reporting measures in 2017
  - Consolidate current MU & PQRS efforts under one leadership
  - Evaluate required organizational or staffing changes
- Understand which track your organization will likely be classified as (MIPS, Non Advanced APM MIPS, or Advanced APM)
  - For MIPS track, estimate your score and understand how to target improvement.
  - If APM status is in question be prepared to submit for MIPS at least 90 days in advance of the year end.
- Educate your providers on your payment track and how it will affect Medicare provider reimbursement in 2019 and beyond.

CRITICAL SUCCESS FACTORS

1. If not already in an Advanced APM or meeting MIPS requirements, get started as soon as possible in 2017 but no later than the end of the third quarter to allow for 90 days of MIPS measures submissions. Preferably meet requirements in all categories for 90 days. This will determine how 2019 reimbursement is impacted in the range of -4% to +12%.
2. The Advanced APM model has potentially large benefits but few will qualify in 2017 for 2019 payments, and there is both upside and downside risks that must be considered.
3. Note that new CPC+ (Comprehensive Primary Care +) model may facilitate easier Advanced APM participation.
4. Medicare Advantage: full risk full cap full reward may ultimately be Advanced APM certified but is not approved as an advanced APM for 2017.
5. Smaller practices are projected to do poorly. Provider groups require scale to efficiently comply. Administrative and clinical “roll ups” may be necessary to reduce overhead.
6. Consider developing care management across the continuum with narrow networks and preferred partners to better manage and optimize scoring.

Telehealth & MACRA

Section 106 of PL 114-10

MACRA requires a GAO study on the telehealth services and remote patient monitoring.

Of note, the legislation directs GAO to look at issues such as professional licensure, privacy and security, and the impact of telehealth on payment and delivery reform.

(1) Study on telehealth services.--The Comptroller General of the United States shall conduct a study on the following:

(A) How the definition of telehealth across various Federal programs and Federal efforts can inform the use of telehealth in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(B) Issues that can facilitate or inhibit the use of telehealth under the Medicare program under such title, including oversight and professional licensure, changing technology, privacy and security, infrastructure requirements, and varying needs across urban and rural areas.

(C) Potential implications of greater use of telehealth with respect to payment and delivery system transformations under the Medicare program under such title XVIII and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(D) How the Centers for Medicare & Medicaid Services monitors payments made under the Medicare program under such title XVIII to providers for telehealth services.

(2) Study on remote patient monitoring services.--

(A) In general.--The Comptroller General of the United States shall conduct a study--

(i) of the dissemination of remote patient monitoring technology in the private health insurance market;

(ii) of the financial incentives in the private health insurance market relating to adoption of such technology;

(iii) of the barriers to adoption of such services under the Medicare program under title XVIII of the Social Security Act;

(iv) that evaluates the patients, conditions, and clinical circumstances that could most benefit from remote patient monitoring services; and

(v) that evaluates the challenges related to establishing appropriate valuation for remote patient monitoring services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) in order

Telehealth & MACRA

Section 101 of PL 114-10

MACRA requires that the Secretary of HHS consider telehealth as an Improvement Activity under the subcategory of care coordination for purposes of MIPS performance and scoring.

``(iii) Clinical practice improvement activities.--For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

``(I) The subcategory of expanded practice access, such as same day appointments for urgent needs and after hours access to clinician advice.

``(II) The subcategory of population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

``(III) The subcategory of care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

``(IV) The subcategory of beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms.

``(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

``(VI) The subcategory of participation in an alternative payment model (as defined in section 1833(z)(3)(C)).

Telehealth & MACRA

- Telehealth integrated into an IA -

TABLE 26—FINALIZED IMPROVEMENT ACTIVITIES ASSIGNED THE HIGHEST POINTS—Continued

Subcategory	Activity
Population Management	MIPS eligible clinicians and MIPS eligible clinician and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, in the first performance period, 60 percent or more of their ambulatory care patients receiving warfarin are being managed by one or more of these improvement activities: Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic INR testing, tracking, follow-up, and patient communication of results and dosing decisions; Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic INR testing, tracking, follow-up, and patient communication of results and dosing decisions; For rural or remote patient, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic INR testing, tracking, follow-up, and patient communication of results and dosing decisions; and/or For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program. The performance threshold will increase to 75 percent for the second performance period and onward. Clinicians would attest that, 60 percent for the transition year, or 75 percent in future years, of their ambulatory care patients receiving warfarin participated in an anticoagulation management program for at least 90 days during the performance period.

Telehealth & MACRA

Telemedicine largely left out of MACRA

By **DAVID PITTMAN** | 10/19/16 10:01 AM EDT

With help from Brianna Ehley (@Briannaehley)

TELEHEALTH: MACRA's FORGOTTEN CHILD: Telemedicine advocates in Washington are "disappointed" that Friday's MACRA rule largely ignores their technology. But they're using it as a reason to support congressional action to give Medicare greater freedom to pay for telemedicine.

— The 2015 MACRA law called for telehealth and remote monitoring to be included in scoring for the Merit-based Incentive Payment Program. But the CMS rule only included a couple of ways to use the technology. The agency said Medicare's long-standing legal limits on only paying for live interactions at rural facilities as the reason for the little mention of telehealth. "CMS has nearly disregarded MACRA's statutory language on remote monitoring and telehealth," Robert Jarrin, senior director of government affairs at Qualcomm, told Morning eHealth. "It's shockingly disappointing."

Telehealth & MACRA

Quality Payment Program Fact Sheet

Annual Call for Measures and Activities

The Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaced a patchwork collection of programs (the Medicare Electronic Health Record (EHR) Incentive Program, the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier with a single system where every Medicare physician and clinician has a chance to be rewarded for better care. You'll be able to practice as you always have, but you may receive higher Medicare payments based on your performance. There are two (2) paths in the Quality Payment Program:

- Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)

Under MIPS, there are four connected categories that will affect your Medicare payments – quality, clinical practice improvement activities (referred to as "improvement activities"), use of certified EHR technology (referred to as "advancing care information"), and resource use (referred to as "cost").

The Annual Call for Measures and Activities for MIPS

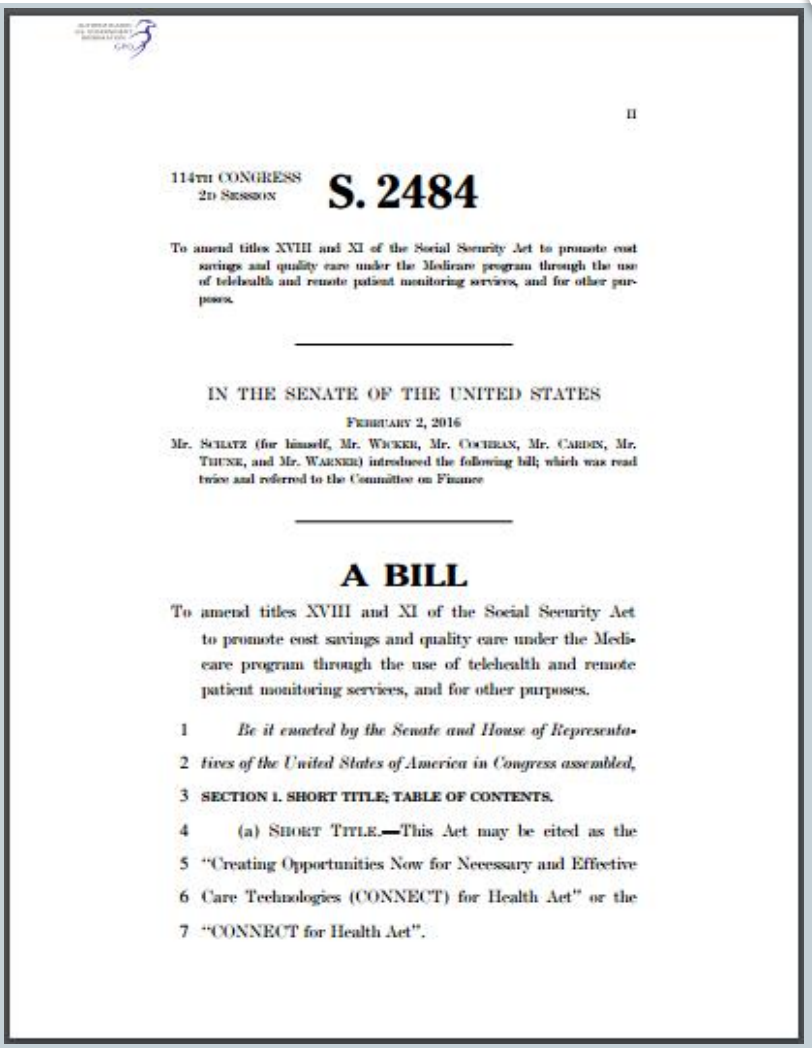
The *Annual Call for Measures and Activities* process allows clinicians and organizations, including but not limited to those representing eligible clinicians such as professional associations, and medical societies, and other stakeholders such as researchers and consumer groups to identify and submit:

- Quality measures for the quality performance category;
- EHR measures for the advancing care information performance category; and
- Activities for the improvement activities performance categories for consideration.

CMS released an Annual Call for Measures and Activities to solicit recommendations for Improvement Activities and Advancing Care Information measures.

Some telehealth stakeholders utilized this opportunity to propose additional telehealth and remote patient monitoring activities as IA and ACI measures.

Telehealth & MACRA



II

114TH CONGRESS
2D SESSION

S. 2484

To amend titles XVIII and XI of the Social Security Act to promote cost savings and quality care under the Medicare program through the use of telehealth and remote patient monitoring services, and for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 2, 2016

Mr. SCHATZ (for himself, Mr. WICKER, Mr. COCHRAN, Mr. CARDIN, Mr. THUNE, and Mr. WARNER) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend titles XVIII and XI of the Social Security Act to promote cost savings and quality care under the Medicare program through the use of telehealth and remote patient monitoring services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act" or the "CONNECT for Health Act".

The CONNECT for Health Act would allow telehealth and remote patient monitoring to be basic benefits for MA plan beneficiaries.

The Act would reimburse such services without §1834(m) geographic restrictions.

TECHNICAL ASSISTANCE FOR CLINICIANS

- **CMS has free resources:**
  - Quality Payment Program Web Site – https://qpp.cms.gov/
  - QPP Service Center – 866-208-82/92 or qpp@cms.hhs.gov
  - Primary Care & Specialists – Transforming Clinical Practice Initiative (TCPI)
  - Small, Underserved and Rural Practices – SURS
  - Large Practices – State QIO

Questions?

Jonathan Joseph
Partner
Christian & Barton, LLP
Richmond, VA
804.697.4125
jjoseph@cblaw.com

Cybil Roehrenbeck
Counsel
Polsinelli PC
Washington, DC
202.777.8931
croehrenbeck@polsinelli.com

Karen Meador
Consulting Managing Director
BDO
New York, NY
214.259.1477
kmeador@bdo.com