



# 2018 regulatory relief dashboard

## Regulatory wins

### Quality Payment Program (QPP) legislative wins in the “Bipartisan Budget Act of 2018”

- Excludes Medicare Part B drug costs from Merit-based Incentive Payment System (MIPS) payment adjustments and from the low-volume threshold determination
  - Eliminates improvement scoring for the cost performance category for the third, fourth and fifth years of MIPS
  - Allows the Centers for Medicare & Medicaid Services (CMS) to reweight the cost performance category to not less than 10 percent for the third, fourth and fifth years of MIPS
  - Extends CMS flexibility in setting the performance threshold for years three through five to ensure a gradual and incremental transition to the performance threshold set at the mean or median for the sixth year
  - Allows the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to provide initial feedback regarding the extent to which models meet criteria and an explanation of the basis for the feedback
- Triples low-volume threshold exemption to \$90,000 or 200 Medicare beneficiaries
    - According to CMS estimates, this change increases the number of MIPS-exempted clinicians by more than 40 percent from an estimated 383,514 in 2017 to 540,347 in 2018
  - Initiates virtual groups
  - Provides favorable scoring and reduced requirements for small practices, including five additional bonus points added to their final performance scores and exemption from ACI reporting
  - Postpones mandate for physicians to upgrade to 2015 edition certified EHRs
    - Saves physicians from needing to choose among only three percent of all available health IT products for their next EHR upgrade and needing to report on new measures
  - ACI component retains flexibility and 90-day reporting period for 2018
  - Does not increase requirements for number of quality measures and establishes a process for topped out measures
  - Physicians only have to report on six quality measures (as opposed to nine under PQRS), of which one must be an outcome measure, on 60 percent of applicable patients
    - CMS outlined criteria that must be met, as well as a gradual removal process for topped out measures
  - Secures relief from MIPS penalties for eligible clinicians in FEMA’s designated areas affected by Northern California wildfires and hurricanes Harvey, Irma, Maria and Nate

### Wins in QPP final rule

- Makes 2018 another transitional year
  - As a result, 90 percent of physicians in practices of 1–15 eligible clinicians and 97 percent of physicians in all practice sizes are estimated to receive a neutral or positive payment adjustment in 2020

- Keeps reporting on Consumer Assessment of Healthcare Providers and Systems (CAHPS) as optional
  - Under PQRS, if a practice was reporting as a group, it was required to report on CG-CAHPS, which was a costly requirement and excluded certain specialties from reporting as a group
- Adds bonus points to overall score for physicians who treat complex patients to account for clinical and social risk factors
  - The additional points will better ensure physicians who treat complex patients are not at a disadvantage under MIPS and give them a greater chance of earning an incentive
- Maintains simple Improvement Activity reporting through attestation and adds CME to list of eligible activities
- Announces new physician-led direction for alternative payment models
- Secured multiple physician slots on key USP Advisory Committee, which deals with issues like in-office compounding
- Office of the National Coordinator promotes AMA STEPS Forward™ modules with the Federal Health IT Playbook
- The administration recognizes the unique cybersecurity needs of small practices
- Medicare administrative contractors begin to use targeted modeling for audits that emphasizes education to prevent billing errors before they are referred to recovery audit contractors (RACs)
- CMS clarifies contractor functions to eliminate duplicate reviews
- CMS auditors use predictive analytics to focus audits on claims that are at high risk for improper payments

### **Other regulatory wins**

- CMS retroactively modifies 2016 PQRS, Meaningful Use (MU) and value-based payment modifier policies to align with MIPS; changes will reduce penalties for physicians in 2018
  - CMS estimates that 23,625 eligible clinicians will avoid a total of \$22 million in 2018 PQRS penalties as a result of the change to PQRS requirements
- CMS proposes to remove a number of quality measures from various inpatient hospital reporting programs
- Physicians may now use medical student documentation of components of E/M services, as long as the physician verifies the student's documentation
- VA only exempts employed physicians from multistate licensure requirements when delivering telehealth services
- Congress requires CMS to replace beneficiaries' social security number on Medicare cards; CMS agrees to create look-up tool for physicians and launch an education campaign
- CMS delays implementation of appropriate-use criteria
- FDA signals its plans to accommodate physicians preparing sterile drug products in office settings

### **Other EHR wins**

- A provision in the "Bipartisan Budget Act of 2018" removes the current mandate that MU standards become more stringent over time; this eases the burden on physicians as they may no longer have to submit and receive a hardship exception from the U.S. Department of Health & Human Services (HHS)
- Vendors must communicate to physicians the fees associated with EHR functions
- Law passed preventing vendors from data blocking
- Law passed requiring reduction of EHR burdens
- EHRs must now include enhanced interoperability technology and support for apps
- With new EHR upgrades, physicians will have access to dozens of new, innovative medical applications to improve their EHR's usability
- Physicians can now register complaints with an EHR product directly to the federal government for action
  - To date, over 180 EHR products have been identified as not being compliant with federal certification requirements

- In the inpatient setting, CMS proposes to:
  - Eliminate many measures, including those that have been difficult for physicians to meet, such as “View, Download, Transmit”
  - Move away from pass/fail scoring system
  - Allow 90-day reporting periods in 2019 and 2020

## Top “Asks”

### Top QPP “Asks” of CMS—providing flexibility and reducing the burden of QPP are top regulatory relief priorities

- Simplify MIPS scoring methodology
- Provide timely notification to practices that qualify for special treatment and exceptions
- Ensure methodology and data are sound before scoring physician improvement
- Provide maximum flexibility for virtual groups
- Maintain the quality data completeness criteria; modify the quality provisions on topped-out measures and benchmarks; and eliminate requirements related to outcome measures, all-payer data and administrative claims measures
- Keep weight in the cost category low in the next three years while better measures are developed
- Align ACI measures with IPPS measures to reduce burden on physicians
- Reduce the number of measures in the ACI category, promote the use of certified and non-certified technology, and grant physicians full ACI credit for using certified EHRs to participate in a qualified clinical data registry
- Allow physicians to report for a minimum of 90 days

### Alternative payment models (APMs)

- Phase in and extend the eight percent revenue-based nominal risk standard for the foreseeable future
- Extend medical home risk standard to small and rural practices participating in all advanced APM models
- Include medical home models with specialty practices
- Do not restrict medical home risk standard to organizations with fewer than 50 clinicians

### EHRs—working with administration to implement regulations

- Prevent health IT vendors from blocking information or making it expensive for physicians to share data with other clinicians, their patients and registries
- Ensure physicians have support for when they and their patients want to use apps on their EHRs
- Improve the way health information networks communicate with one another
- Test the interoperability and usability of EHRs in real-world environments

### Other regulatory “Asks” of the administration

- CMS should reaffirm physicians’ right to refuse virtual credit card payments and receive basic standard electronic funds transfer without fees imposed by health plans or their vendors
- CMS should reduce certification requirements and standardize forms
- Federal agencies should not require the unique identifier on administrative claims forms
- The U.S. Drug Enforcement Administration should reduce barriers for physicians to e-prescribe controlled substances
- CMS should ensure it has accurate data before moving forward with new payment methods for clinical tests performed in physician offices
- The HHS Office for Civil Rights should broaden the ways in which a physician can comply with HIPAA
- HHS should allow hospitals and large health care organizations to donate cybersecurity support and resources to physician practices
- CMS should clarify that certain data may be recorded in the medical record by non-physician staff
- CMS should simplify documentation requirements for physicians to support medical advantage (MA) risk-adjustment scores
- CMS should refine its MA star ratings criteria to focus less on physician data collection and administrative demands

## **Program integrity**

- Create new exceptions/safe harbors for Stark and anti-kickback statutes to facilitate coordinated care
- Rescind the two-midnights rule
- Count outpatient time in hospital toward three-day requirement for skilled nursing services

## **RACs**

- Limit medical records requests
- Reimburse costs of physicians who win on appeal
- Require audits to be reviewed by physicians of same specialty

## **Other auditor issues**

- Develop uniform approach among auditors
- Require audits to be reviewed by a physician in the same specialty
- Fine contractors when denials are overturned on appeal

## **Other regulatory relief legislative “Asks”**

- The U.S. House of Representatives Committee on Ways and Means has undertaken an initiative known as the Medicare Red Tape Relief Project to “reduce the Medicare regulations and mandates that too often stand in the way of delivering quality patient care.” On March 15, the AMA, along with several other physician groups, participated in a Ways and Means Committee roundtable that focused on Medicare regulatory relief items that the committee can work to address this year. Issues raised by the AMA include improvements to MIPS, virtual credit cards and prior authorization. The AMA looks forward to continuing to work with the committee to lessen the burden of regulations that do not contribute to improving patient care.