2018 regulatory relief dashboard

Regulatory wins

Wins in Quality Payment Program (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

• 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

• Postpones mandate for physicians to upgrade to 2015 edition certified EHRs
  — Saved physicians from needing to choose among only 3 percent of all available health IT products for their next EHR upgrade

• ACI component retained flexibility 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

• Secured relief from MIPS penalties for eligible clinicians in FEMA’s designated areas affected by Northern California wildfires and hurricanes Harvey, Irma, Maria and Nate

• Keeps reporting on 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
  — Add 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

• Announced new physician-led direction for alternative payment models

Other regulatory wins

• CMS retroactively modifies 2016 PQRS and VBM 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

• Congress requires CMS to replace beneficiaries’ social security number on Medicare cards; CMS agrees to create look-up tool for physicians and an education campaign
• CMS delays implementation of appropriate use criteria

• CMS affirms physicians’ right to refuse virtual credit card payments and receive basic standard electronic funds transfer without fees imposed by health plans or their vendors

• ONC promotes Steps Forward™ modules with the Federal Health IT Playbook

• The administration recognizes the unique cybersecurity needs of small practices

• MACs begin to use targeted modeling for audits that emphasizes education to prevent billing errors before they are referred to the 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 EHR wins

• 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 the 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 100 EHR products have been identified as not being compliant with federal certification requirements

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 improvement

• Provide the maximum flexibility for virtual groups

• Maintain the quality data completeness criteria; modify the quality provisions on topped-out measures and benchmarks; eliminate requirements related to outcome measures, all-payer data and administrative claims measures

• Keep cost weight low in next three years while better measures are developed

• Add flexibility to the ACI category, reduce data blocking attestation requirements, grant physicians ACI credit for using CEHRT EHR to participate in a QCDR

APMs

• Phase-in and extend the 8 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

QPP legislative “Asks”

• Extend flexibility beyond 2018 to set thresholds at a level other than mean or median

• Extend flexibility beyond 2018 to weigh costs at less than 30 percent of total score

• Do not include Part B drugs in MIPS calculations or payment adjustments

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Other regulatory “Asks” of the administration

- Reduce certification requirements and standardize forms
- Do not require the unique identifier on administrative claims forms
- DEA should reduce barriers for physicians to prescribe controlled substances
- CMS should ensure it has accurate data before the agency moves forward with new payment methods for clinical tests performed in physician offices
- Protect from random OCR HIPAA security audits if a physician implements a cybersecurity framework
- Allow hospitals and large health care organizations to donate cybersecurity support and resources to physician practices
- FDA and USP should continue to allow in-office preparation of sterile drug products by physicians by exempting this practice from definition of compounding
- 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 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 request
- Reimburse physicians for medical records
- Reimburse costs of physicians who win on appeal
- Require audits to be reviewed by physicians of same specialty

Other auditors

- 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.” 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.