Regulatory wins

**Wins in Quality Payment Program (QPP) proposed rule**
- Makes 2018 another transitional year
- Triples low-volume threshold exemption to $90,000 or 200 Medicare beneficiaries
- Initiates virtual groups
- Helps small practices with exemption from ACI and additional bonus points
- Postpones mandate for physicians to upgrade to 2015 edition certified EHRs
- Does not increase requirements for number of quality measures or data completeness
- Keeps cost category’s weight at zero in 2018

*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*  
*MACs begin to use targeted modeling for audits*  
*Policy included in Proposed Physician Fee Schedule Rule*

**Other regulatory wins**
- CMS retroactively modifies 2016 PQRS, MU, and VBM policies to align with MIPS; changes will reduce penalties for physicians in 2018*

*Policy included in Proposed Physician Fee Schedule Rule*

**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
- Physicians can now register complaints with an EHR product directly to the federal government for action

**Top “Asks”**

**Top QPP “Asks” of CMS—providing flexibility and reducing the burden of QPP are top regulatory relief priorities**
- Set composite score performance threshold at six rather than 15
- Do not include Part B drugs in MIPS calculations or payment adjustments
- 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*

*Finalize zero cost weight for 2018 and keep 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

• Avoid adding complexity to the “Improvement Activity” category

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

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

• FDA & 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

• Eliminate duplicate reviews

• Use predictive modeling to focus audits on outliers

• Emphasize education to prevent billing errors

• Require audits to be reviewed by a physician in the same specialty

• Fine contractors when denials are overturned on appeal
The American Medical Association and more than 100 other organizations representing physicians, hospitals, pharmacists, medical groups, and patients have endorsed 21 Prior Authorization and Utilization Management Reform Principles that are intended to serve as best practices and reasonable reforms for utilization management (UM) programs. The AMA is urging CMS to incorporate these principles into Medicare prior authorization (PA) programs, including the adoption of a national electronic standard for pharmacy PA under Medicare Part D and medical services demonstrations. In addition, the AMA has:

- Engaged in ongoing discussions with national health plans, insurer associations, and accreditation organizations to reform PA programs in accordance with the PA principles
- Partnered with the University of Southern California Schaeffer Center for Health Policy & Economics on a research project establishing general PA trends and impact of PA on patient outcomes for specific disease state/drug class