



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
- Allows a combination of data collection types for quality category
- Implements new episode-based cost measures developed with significant clinical expertise and continues to work with physician community to develop additional episode-based cost measures
 - The American Medical Association supports this effort but believes that CMS should keep weight of the cost category at 10 percent while measures are expanded and evaluated
- Eliminates many promoting interoperability (PI) measures, including ones that have been difficult for physicians to meet, such as “View, Download, Transmit”
- PI moves away from pass/fail scoring system
- 90-day reporting periods for all but the quality component in 2019 and 2020
- Removes requirement that electronic health records (EHR) send and receive multiple-page documents when a summary is all that is needed
- Provides a pass to physicians whose EHRs cannot electronically receive or use information from other clinicians
- Eliminates PI’s base/performance structure
- Reduces confusion by creating a single set of four objectives to report on in PI
- Provides bonus credit to physicians who check prescription drug monitoring programs
- Provides more choice for physicians on how to get credit for registry participation
- Maintains the attestation reporting option and 90-day reporting period for improvement activities
- Provides physicians an exemption from the PI performance category if their EHR vendors do not provide 2015 Edition EHRs next year

Wins in QPP proposed rule

- Makes 2019 another transitional year
- Maintains reduced reporting requirements for small practices
- Allows physicians to opt-in to participate in MIPS or create a virtual group if they meet one or two (but not all) of the low-volume threshold elements
- Removes Part B drugs from the low-volume threshold determinations and from physicians’ payment adjustments
- Maintains the complex patient bonus
- Consolidates determination periods for low-volume threshold, non-patient facing physician, small practice and hospital-based physicians

- Maintains the revenue-based financial risk requirement for advanced alternative payment models (APM) at 8 percent of revenues for an additional four years
- Allows participants in other payer APMs to describe their compliance with requirements that 50 percent of APM physicians use Certified EHR Technology (CEHRT), instead of mandating that APM payment contracts explicitly require use of CEHRT
- Certifies other payer APMs as meeting CMS requirements for APMs for up to five years instead of requiring annual reapplications
- Clarifies that APM participants can meet Medicare and other payer participation thresholds using patient counts for one threshold and payment counts for the other threshold, whichever is the most advantageous to the physician
- Waives requirements for MIPS reporting and MIPS payment adjustments for physicians participating in Medicare Advantage APMs, effective in 2018, whether or not the physician also participates in APMs for Medicare fee-for-service patients

Wins in fee schedule *proposed* rule

- Reduces documentation burden for physicians to support medical necessity of the E/M visit, including:
 - Allowing physicians to choose their method of documentation among 1995 or 1997 Evaluation and Management Guidelines, medical decision-making only, and physician time spent face to face with patients
 - No longer requiring physicians to re-document the “History of Present Illness” (after the nurse and other staff have entered it)
 - Permitting interval history—allowing physicians to add only to the record what changed for an established patient
 - Removing the need to justify providing a home visit instead of an office visit
- Allows the presence of the teaching physician during the Evaluation and Management services to be demonstrated by the notes in the medical records made by a physician, resident or nurse
- Covers a number of new services such as brief, non-face-to-face appointments via communications technology (virtual check-ins)
- Expands coverage of telehealth services and modifies or removes limitations relating to geography and patient setting for certain telehealth services,

including end-stage renal disease home dialysis evaluation; diagnosis, evaluation and treatment of an acute stroke; and services furnished by certain practitioners in certain accountable care organizations

Other regulatory wins

- Finalized policies to reduce reporting burden by removing and de-duplicating many quality measures within the hospital quality reporting programs
- CMS aligned the inpatient setting with the proposed PI policies, including:
 - Elimination of many problematic measures
 - Moves away from pass/fail scoring
 - 90-day reporting periods in 2019 and 2020
 - Removed the requirement that EHRs send and receive multiple-page documents when a summary is all that is needed
 - Provides a pass to physicians whose EHRs cannot electronically receive or use information from other clinicians
- Permits a new teaching hospital to loan resident slots to existing teaching hospitals, beginning five years after its caps are set
- CMS decided not to finalize a proposal to reject a cost report for lack of supporting documentation if the Intern and Resident Information System data does not contain the same total counts of direct graduate medical education and indirect medical education full-time equivalent residents that are reported on the Medicare hospital cost report
- The U.S. Food and Drug Administration (FDA) signals its plans to accommodate physicians preparing sterile drug products in office settings
- Secured multiple physician slots on key United States Pharmacopeia (USP) Advisory Committee, which deals with issues like in-office compounding
- USP new draft Chapter 797 for sterile compounding proposes to make significant accommodation for allergen/immunotherapy preparation in physician offices; proposes to create an exception to the full 797 requirements for physicians preparing sterile drug products for administration to patients within one hour of preparation
- The administration begins to re-examine the regulation on self-referral by issuing a Request for Information

Top asks

QPP asks

- Simplify the MIPS scoring methodology
- CMS should reduce the overall performance threshold
- Return the small-practice bonus to overall score rather than the quality category
- Allow physicians and groups the option to submit a minimum of 90 days' worth of quality data
- If CMS reduces the number of quality measures in MIPS, the agency should also reduce the number of requirements for the quality category
- 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 and do not increase the reporting threshold; modify the quality provisions on topped-out measures and benchmarks; eliminate requirements related to outcomes measures, all-payer data and administrative claims measures
- Keep weight in the cost category low during next three years while better measures are developed; revise or eliminate cost measures carried over from the value-based modifier
- Provide a more robust APM pathway under the Quality Payment Program (QPP)

Fee-for-service asks

- CMS should move forward with several of its Evaluation and Management documentation policies to reduce physician burden
- CMS, however, should not move forward with its proposed policy to collapse level two through five for office visits into a single payment; rather, the agency should embrace the Current Procedural Terminology®/RVS Update Committee workgroup and work with the physician community to develop a mutually agreeable policy

Other regulatory asks of the administration

- CMS should reinstate its 2012 policy prohibiting Medicare Advantage plans from using step-therapy protocols for Part B physician-administered medications

- 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 U.S. Department of Health and Human Services (HHS) Office for Civil Rights should broaden the ways that a physician can comply with the Health Insurance Portability and Accountability Act
- HHS should allow hospitals and large health care organizations to donate cybersecurity support and resources to physician practices
- FDA and United States Pharmacopeia should finalize policy that allows in-office preparation of sterile drug products by physicians by exempting physician practices from onerous compounding pharmacy requirements
- 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 Medicare Advantage risk-adjustment scores
- CMS should refine its Medicare Advantage 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

Recovery audit contractors

- Limit medical records requests
- 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 initial AMA submission to the committee covered a wide range of legislative regulatory relief recommendations, including:
 - MIPS recommendations on thresholds, scoring simplification, optional measures, reporting periods, advancing care information improvements, the resource use category, and improvement activities
 - APMs, PTAC, risk
 - Health information technology recommendations related to data blocking, cost transparency and certification
 - Translation services requirements
 - Modernization of Stark and anti-kickback regulations
 - Protecting Access to Medicare Act clinical testing access and pricing
 - Physician ownership of hospitals
 - Prior authorization and utilization management
 - Certification and documentation
 - Program integrity
 - Appropriate use criteria
 - Medicare Advantage star ratings
 - Unique device identifier and claims
 - In-office drug compounding

- On March 15 and again on June 14, the AMA along with several other physician groups, participated in Ways and Means Committee roundtables 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. On Aug. 15, the Committee on Ways and Means released a report on these activities to date, reviewing committee actions, relevant legislation and regulatory steps undertaken by the administration. The committee urged continued engagement by stakeholders and committed to continued work to reduce burdens for health care providers in 2019 and beyond.