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Medicare Value-Based Payment and Quality Reporting for Physician Services: Navigating Recent Changes

Leveraging Incentive Payment Opportunities, Avoiding Reimbursement Penalties and the Future of Medicare Fee-for-Service

THURSDAY, APRIL 23, 2015

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

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McDermott Will & Emery

Medicare Value-Based Purchasing and Quality Reporting for Physician Services: Navigating Recent Changes

April 23, 2015

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Agenda

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- Introduction
- Future of Quality Reporting and Value-Based Payment
- Merit-Based Incentive Payment System (MIPS)
- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VBPM)
- Medicare Electronic Health Record (EHR) Incentive Program

Future of Quality Reporting and Value-Based Payment

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- On January 26, 2015, CMS announced plan to accelerate move of Medicare reimbursement toward value-based payment rather than quantity-based payment (which had rewarded volume and care duplication)
  - Value means quality, including care coordination, and cost-effectiveness
  - Proposes to link 85% of Medicare Part A and Part B payments to quality and value by end of 2016 and 90% by end of 2018
  - Proposes to increase participation in alternative payment models, such as ACOs, to 30% by the end of 2016 and 50% by the end of 2018

CMS and Quality Measure Reporting

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- Key to value-based payment is quality and cost measurement
- How does CMS measure quality?
  - National Quality Forum, a non-profit organization, endorses quality measures proposed through various sources, including medical practice associations, through a consensus development process
- PQRS → Value Based Reimbursement
  - PQRS was established in 2007 as the Physician Quality Reporting Initiative
  - PQRS created a phased approach to value-based payment
  - Initially PQRS incentivized reporting of quality measures through claims or registries, with no downward adjustment for non-reporting, or for poor quality
  - Downward payment adjustments will begin this year for non-reporting of PQRS measures for 2013 reporting year
  - VBPM ties reimbursement to quality and cost-effectiveness

Increasing Reimbursement Dollars at Stake

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- Eligible Professionals (EPs) face penalties of **up to a 9% reduction** in Medicare FFS reimbursement in 2017 if they do not report quality measures and fail to achieve Meaningful Use in 2015
  - -2% for PQRS
  - -4% for VBPM and
  - -3% for Meaningful Use
- CMS predicted that about 257,000 physicians would face payment penalties in 2015 for not achieving Meaningful Use; another 56,000 physicians received a hardship exemption from penalties
- 64% of eligible physicians are not participating successfully in the Medicare EHR Incentive Program and will need to achieve Meaningful Use to avoid penalties

Increasing Reimbursement Dollars at Stake (cont'd)

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- Medicare EHR Incentive Program
  - 2014 was the last year that a Medicare EP could begin to receive incentive payments for achieving Meaningful Use
  - Medicare EPs that achieved Meaningful Use in 2014 or earlier may receive incentive payments in 2015 and 2016 if they achieve Meaningful Use during 2015 and 2016 reporting periods
  - Penalties continue through 2018, with Meaningful Use factoring into MIPS incentive payment or penalty starting in 2019
- VBPM
  - EPs may receive a VBPM incentive payment of **up to 4%** for 2015
  - No incentive payment for participating in PQRS in 2015

Sustainable Growth Rate Fix Bill

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- Congress passed the bipartisan SGR fix bill on April 14, 2015
- SGR fix provides for a 5% payment bonus to eligible professionals who are qualifying alternative payment model participants (i.e., 25% of payments attributable to eligible alternative payment entity in 2019 and 2020)
- Bonus payment may be made on a basis other than fee-for-service (i.e. a capitated basis) depending on the eligible alternative payment entity
- Other eligible professionals who do not participate in a qualifying alternative payment model are subject to MIPS

Merit-Based Incentive Payment System

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- MIPS consolidates Medicare EP requirements of PQRS, VBPM and EHR Incentive Program into one incentive program in 2019
- EPs rated on four weighted performance categories:
  - Quality (30%)
  - Resource Use (30%)
  - Clinical Practice Improvement Activities (15%)
  - Meaningful Use of Certified EHR Technology (25%)
- EP is eligible for an incentive payment or a penalty based on performance – Up to 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022 and subsequent years
- From 2019-2024, EPs who perform exceptionally may receive an additional positive MIPS adjustment factor

Physician Quality Reporting System

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- Medicare FFS payment program to encourage physicians and other EPs to report approved PQRS quality measures
- 2014 was the last year that EPs could earn an incentive payment for PQRS measure reporting
- EPs who fail to satisfactorily report quality measures in 2015 will be subject to a 2.0% downward adjustment in 2017 Medicare Physician Fee Schedule (MPFS) reimbursement
- EPs may report either as an individual EP or part of a group practice under the Group Practice Reporting Option (GPRO)
- EP/group selects quality measures and reporting mechanism

Key PQRS Action Steps

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1. Identify which clinicians are EPs
2. Decide whether to report as individual EP(s) or group
3. If group of < 100 EPs, decide whether you will conduct and report Consumer Assessment of Healthcare Providers and Systems (CAHPS) through a survey vendor (mandatory for ≥ 100 EP groups)
4. Review PQRS quality measures for relevance to practice
   - If a group reporting CAHPS, select 6 measures across 2 National Quality Strategy (NQS) domains to report for at least 50% of your Medicare FFS population
   - If a group ***not*** reporting CAHPS, select 9 measures across 3 NQS domains to report for at least 50% of your Medicare FFS population
   - If reporting individually, select 9 measures across 3 NQS domains to report for at least 50% of your Medicare FFS population ***or*** select a measures group to report for at least 20 patients (the majority of which must be Medicare FFS)
5. Determine the method for reporting the PQRS measures and report measure data

Who needs to participate in PQRS?

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- EPs include:
  - Physicians (e.g., Doctor of Medicine, Doctor of Osteopathy, Doctor of Optometry, Doctor of Dental Medicine)
  - Practitioners (e.g., PA, APN, CNS, CRNA, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Qualified Audiologist)
  - Therapists (e.g., PT, OT, SLP)
- If these professionals provide services paid under the MPFS, they are EPs under the PQRS program
- EPs do not include medical assistants and others without NPI

Selecting PQRS Measures

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- *Individual EPs* must select 9 PQRS quality measures across 3 NQS domains or select a measures group
- *Groups of ≥ 2 EPs* may either select 9 measures across 3 NQS domains; or report CAHPS patient experience survey results and select 6 measures across 2 NQS domains
- *Groups of ≥100 EPs* must report CAHPS patient experience
- EPs or group using claims or registry reporting must report at least one “cross-cutting measure” that CMS deems applicable to all EPs
- For each measure, report for at least 50% of Medicare FFS patients seen during the reporting period to which the measure applies

National Quality Strategy Domains

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- NQS is led by the Agency for Healthcare Research and Quality on behalf of HHS
- 6 NQS Domains include:
  - Person and Caregiver-Centered Experience Outcomes
  - Patient Safety
  - Communication and Care Coordination
  - Community, Population and Public Health
  - Efficiency and Cost Reduction
  - Effective Clinical Care

Measure Group Option for Solo EP

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- EPs who report individually may elect to instead report a “measure group” via a qualified registry
- Measure groups apply to patients with particular conditions, such as diabetes or asthma
- EP selects at least a 20 patient sample with the condition that a majority (e.g., 11 of 20) must be Medicare FFS patients

Measures Applicability Validation

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- If fewer than 9 PQRS measures apply, the EP may report as many as apply (1-8), but CMS will assess whether the EP should have submitted additional applicable measures through the Measures Applicability Validation process
- Clinical Relation/Domain Test
  - CMS will examine “closely related measures” within the same cluster of measures as any of the other quality measures that the EP or group chose to report to determine if any non-reported measures are applicable to the EP or group
- Minimum Threshold Test
  - If CMS determines that the EP or group omitted an applicable measure, and the EP is a claims-based PQRS reporter, CMS will examine if there were more than 15 eligible patients or encounters with respect to the omitted measure(s) during the reporting period
  - If the EP exceeds the minimum threshold for a non-reported measure, the EP will not be credited with satisfactorily reporting for PQRS

Example Clinical Quality Measures - Ophthalmology

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- **Primary Open-Angle Glaucoma (POAG)**
  - Patients receive Optic Nerve Head Evaluation
- **Age-Regulated Macular Degeneration (AMD)**
  - Dilated Macular Examination performed on patients 50 years or older
- **Diabetic Retinopathy**
  - Documented communication of findings of macular or fundus exam to physician who manages the on-going care of patients 18 years and older with diabetes mellitus
- **Diabetes Mellitus**
  - Patients aged 18 through 75 years with diabetes mellitus who had a dilated eye exam

Ophthalmology Measure Group Example

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- **Cataracts Measures Group** (registry reporting only)
  - 20/40 or better visual acuity within 90 days following surgery
  - Complications within 30 days following cataract surgery requiring additional surgical procedures
  - Improvement in visual function within 90 days following surgery, based on pre-operative and postoperative visual function survey
  - Patients satisfied with care within 90 days following surgery, based on completion of the CAHPS Surgical Care Survey

Example Clinical Quality Measures - Dermatology

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- **Melanoma: Continuity of Care**
  - Patients entered into a recall system
- **Melanoma: Coordination of Care**
  - Treatment plan shared with physician providing continuing care
- **Melanoma: Efficiency and Cost Reduction**
  - Patients without signs or symptoms suggesting systemic spread for whom no diagnostic imaging studies were ordered
- **Melanoma: Communication and Care Coordination**
  - Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on the thickness and ulceration for pT1, mitotic rate
- **Biopsy Follow-Up**
  - Biopsy results reviewed and communicated to primary care/referring physician and patient
- **TB Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biologic**
  - Patients on biologics screened annually for TB, with review of patient's history to determine appropriate management for a prior positive test

Example Clinical Quality Measures – Cross-Cutting Measures

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- **Documentation of Current Medications in the Medical Record**
  - Patients aged 18 years and older for which the EP attests to documenting all current medications based on immediate resources available on data of encounter
- **Pain Assessment and Follow-up**
  - Patients aged 18 years and older with documentation of a pain assessment using a standardized tool on each visit
- **Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention**
  - Patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and received cessation counseling if a tobacco user
- **Medication Reconciliation**
  - Patients aged 65 years and older discharged from any inpatient facility and seen within 30 days following discharge who had a reconciliation of discharge medications with the current medications list in the outpatient medical record
- **Care Plan**
  - Patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation that advanced care plan was discussed

How may *individual* EPs report PQRS measures in 2015?

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- Within Medicare Part B claims
  - Submit Quality-Data Codes (QDCs – which are specified CPT II codes and G-codes) within Medicare claims
- Qualified PQRS registry
- Directly from Certified EHR Technology (CEHRT)
- Data Submission Vendor that is a CEHRT vendor
- Qualified Clinical Data Registry (QCDR)
  - Differs from a qualified registry in that it is not limited to measures within PQRS; QCDR may submit a maximum of 30 non-PQRS measures
  - In addition to reporting 9 measures covering 3 NQS domains, an EP participating through a QCDR must report at least 2 outcome measures (if possible through the particular QCDR)

How may group practices report PQRS measures in 2015?

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- Qualified PQRS registry
- Web interface (for groups of ≥ 25 EPs only)
  - Secure internet-based application allows pre-registered groups to upload data from CEHRT to the interface via an XML file
- Directly from CEHRT
- Data Submission Vendor that is a CEHRT vendor
- CAHPS CMS-certified survey vendor
  - *Groups of ≥100 EPs must report CAHPS patient experience survey data through a CMS-certified survey vendor for successful PQRS reporting*
  - *Group practices of 2-99 EPs have the option to report CAHPS survey results through a CMS-certified survey vendor*

Key PQRS Action Steps (Reprise)

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1. Identify which clinicians are EPs
2. Decide whether to report as individual EP(s) or group
3. If group of < 100 EPs, decide whether you will conduct and report Consumer Assessment of Healthcare Providers and Systems (CAHPS) through a survey vendor (mandatory for ≥ 100 EP groups)
4. Review PQRS measures for relevance to practice
   - If a group reporting CAHPS, select 6 measures across 2 NQS domains to report for at least 50% of your Medicare FFS population
   - If a group ***not*** reporting CAHPS, select 9 measures across 3 NQS domains to report for at least 50% of your Medicare FFS population
   - If reporting individually, select 9 measures across 3 NQS domains to report for at least 50% of your Medicare FFS population ***or*** select a measures group to report for at least 20 patients (the majority of which must be Medicare FFS)
5. Determine PQRS measure reporting method and report measure data

Value Based Payment Modifier

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- Affordable Care Act requires CMS to apply a VBPM to make performance-based adjustments to MPFS fee-for-service reimbursement to solo practitioner EPs and group practices
- MPFS payment adjustments are phased in based on group size for physician EPs from 2015 – 2017 and begin for non-physician EPs in 2018
- Increase or decrease is based upon "quality tiering" that combines a "quality measure composite score" and a "cost measure composite score" to assign EP to one of three tiers
  - Performance above national mean results in MPFS rate increase
  - Average performance has a neutral effect on MPFS rates
  - Performance below national mean result in a MPFS rate decrease

VBPM Quality Composite Score

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- Quality composite score based on:
  - PQRS measures reported by group/physician EP and
  - 3 outcomes measures that CMS calculates based on claims data
    - All-cause readmissions
    - Composite of acute prevention quality indicators (dehydration, urinary tract infections and bacterial pneumonia)
    - Composite of chronic prevention quality indicators (heart failure, chronic obstructive pulmonary disease and diabetes)
- For outcomes measures (and cost measures discussed later), CMS attributes beneficiaries to practice that provided plurality of E & M and other primary care services to that beneficiary
- Option for groups of 2 or more to include CAHPS measures or patient experience of care measures and *required for groups* ≥ 100 EPs

VBPM Quality Composite Score (Cont'd)

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- Failure to report PQRS measures will lead to both downward PQRS and VBPM payment adjustments
- For purposes of VBPM, groups may report PQRS measures under GPRO option or ensure >50% of EPs report individually
- CMS determines quality tiers and calculates the VBPM at the group level, with the exception of solo practitioners (calculated individually)

VBPM Cost Composite Score for 2015

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- CMS calculates "cost composite score" based on composite of the following 3 measures:
  - *Total Per Capita Cost for all Beneficiaries*: Considers all Medicare Part A and B costs over a year
  - *Total per Capita Costs for all Beneficiaries with 4 Chronic Conditions*: Considers Part A and Part B costs for patients with COPD, Heart Failure, Diabetes and Coronary Artery Disease
  - *Medicare Spending per Beneficiary Associated with Hospitalization*: Evaluates Part A and Part B costs spanning 3 days prior to and 30 days after a hospital admission
- All cost measures are standardized and risk adjusted based on *national* benchmarks

Who is affected by VBPM?

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- CMS is phasing in downward MPFS payment adjustment through VBPM over the next two years
- In 2015, only physicians in groups of ≥ 100 EPs reassigning to a single Tax Identification Number (TIN) receive an upward, neutral or downward MPFS payment adjustment based on **2013 data reporting**
- In 2016:
  - Physicians in groups of 10-99 EPs under a single TIN are subject to VBPM downward payment adjustment for **non-reporting of 2014** PQRS measures and neutral or upward adjustment based on **2014 quality tiering**, but not downward adjustment
  - Physicians in groups of ≥ 100 EPs may receive upward, neutral or downward VBPM payment adjustment based on **2014 quality tiering**

Who is affected by VBPM?

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- In 2017:
  - All physicians who are reimbursed under the MPFS are eligible for a VBPM downward payment adjustment based on the **non-reporting of PQRS measures for 2015**
    - - 2.0% for solo practitioners and physician groups with 2-9 EPs
    - - 4.0% for physician groups with ≥ 10 EPs
  - Solo practitioners and physicians within groups of 2-9 EPs will not be subject to downward adjustment in 2017 on the basis of **2015 quality tiering**, but may receive upward or neutral adjustment
  - Physicians in groups with ≥ 10 EPs will be subject to upward, neutral or downward payment adjustment based on **2015 quality tiering**

What are the 2017 VPBM payment adjustments based on the 2015 reporting year?

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Physicians in groups with ≥ 10 EPs[1]:

Quality/Cost	Low Cost	Average Cost	High Cost
High Quality	+4.0x	+2.0x	+0
Average Quality	+2.0x	+0	-2.0
Low Quality	+0	-2.0	-4.0

Solo practitioners and groups with 2-9 EPs who satisfactorily report PQRS[1]:

Quality/Cost	Low Cost	Average Cost	High Cost
High Quality	+2.0x	+1.0x	+0
Average Quality	+1.0x	+0	+0
Low Quality	+0	+0	+0

- The 'x' represents the "upward payment adjustment factor", which CMS will determine based on the aggregate amount of downward payment adjustments in CY 2015 in order to ensure budget neutrality
- Groups and solo practitioners are eligible for an additional +1.0x if they report PQRS and their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide

[1] Revisions to Payment Policies Under the Physician Fee Schedule; Final Rule, 79 Fed Reg. 67548, 67953 (Nov. 13, 2014)

PQRS and VPBM Example

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- A group has four physicians and a PA. Three of the four physicians individually report PQRS quality measures satisfactorily for the 2015 reporting year. The PA and the fourth physician do not report measures for PQRS. When CMS performs quality tiering on the practice group, it rates the group in the "average quality" and "high cost" tiers.

    1. Will the non-reporting physician be subject to downward adjustment in 2017 under PQRS? How about the PA?
    2. Will the practice group be subject to downward payment adjustment in 2017 under VPBM?

PQRS and VPBM Example Answers

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1. The non-reporting physicians and the PA, assuming they both bill Medicare Part B FFS, will be subject to a 2.0% downward payment adjustment in 2017 under PQRS for the Medicare Part B FFS services they provide.
2. As more than 50% of the EPs in the group satisfactorily reported PQRS, the physicians within the practice group will not be subject to a downward VBPM in 2017 for Part B FFS claims under the group's TIN. Although the group was rated in the "high cost" category, groups of 2-9 EPs will not face downward adjustment based on quality tiering in 2017.

EHR Incentive Program

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- Medicare EHR Incentive Program provides payments to certain eligible professionals who achieve “Meaningful Use” of CEHRT by meeting certain Meaningful Use measures
- EPs must choose either Medicare OR Medicaid EHR incentives
- Downward MPFS payment adjustments for failing to achieve Meaningful Use begin in 2015 based on whether EP achieved Meaningful Use in a prior reporting period
- While 2016 is the final year that incentive payments are available, EPs must continue to achieve Meaningful Use in the reporting period for each calendar year to avoid downward adjustments

Which professionals are eligible to participate in the Medicare EHR Incentive Program?

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- The EP definition for the Medicare EHR Incentive Program is narrower than the definition for PQRS and VBPM
- EHR Incentive Program Eligible Professionals:
  - Doctors of medicine or osteopathy
  - Doctors of dental surgery or dental medicine
  - Doctors of podiatry
  - Doctors of optometry
  - Chiropractors

Key Requirements for Medicare EPs to Achieve Meaningful Use in 2015

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- Implement CEHRT certified under 2014 Edition Criteria
  - "Complete EHR" or a collection of "EHR Modules"
- Register with CMS for EHR Incentive Program
- Achieve Meaningful Use in Applicable Reporting Period
  - Stage 1 (13 core objectives, 5 menu objectives from a list of 9)
  - Stage 2 (17 core objectives, 3 menu objectives from a list of 6)
- Report 9 Clinical Quality Measures (CQMs) for 2015†
- Submit Attestation of Meaningful Use to CMS

EP Registration and Attestation

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- EPs register and attest to Meaningful Use online through the Medicare & Medicaid Program Registration & Attestation System, at:
  - https://ehrincentives.cms.gov/hitech/
- CMS offers user guides for registration and Stage 1 and 2 attestation on its website:
  - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html
- CMS specification sheets include important information on achieving Stage 1 and Stage 2 Meaningful Use measures

Timeline for achieving and attesting to Meaningful Use in 2015

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- 2015 Reporting Period
  - Currently, all Medicare EPs who achieved Meaningful Use in 2014 are required achieve it for a full year in CY 2015. CMS, however, on April 10th, issued a proposed rule that if finalized would change the 2015 reporting period to 90 days for all Medicare EPs.
  - 90-day reporting period for Medicare EPs entering the EHR Incentive Program in 2015
- Attestation deadline for 2015 reporting period: 2/29/2016
- Achievement of Meaningful Use in 2015 required to avoid 2017 MPFS payment adjustments
- CQM reporting would also be reduced to 90 days in 2015, but full year reporting still required for 2015 PQRS and VBPM reporting period

EHR Incentive Payment Amounts

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- Medicare will pay EHR incentive payments through 2016, but 2014 was the final year that EPs could begin to earn incentive payments for achieving Meaningful Use[1]:

	First Payment Received in 2011	First Payment Received in 2012	First Payment Received in 2013	First Payment Received in 2014
Payment Amount in 2011	$18,000			
Payment Amount in 2012	$12,000	$18,000		
Payment Amount in 2013	$7,840 Reduction* ($160)	$11,760 Reduction* ($240)	$14,700 Reduction* ($300)	
Payment Amount in 2014	$3,920 Reduction* ($80)	$7,840 Reduction* ($160)	$11,760 Reduction* ($240)	$11,760 Reduction* ($240)
Payment Amount in 2015	$1,960 Reduction* ($40)	$3,920 Reduction* ($80)	$7,840 Reduction* ($160)	$7,840 Reduction* ($160)
Payment Amount in 2016		$1,960 Reduction* ($40)	$3,920 Reduction* ($80)	$3,920 Reduction* ($80)
TOTAL Incentive Payments	**$43,720**	**$43,480**	**$38,220**	**$23,520**

*Sequestration required a 2% reduction in incentive payments

[1] CMS EHR Incentive Programs Website - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html

Calculation of Downward Adjustments

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% Adjustment Assuming that Less than 75 Percent of Eligible Professionals Are Meaningful Users[1]						
	2015	**2016**	**2017**	**2018**	**2019**	**2020+**
EP **is not** subject to the payment adjustment for eRx in 2014	1.0%	2.0%	3.0%	4.0%	5.0%	5.0%
EP **is** subject to the payment adjustment for eRx in 2014	2.0%	2.0%	3.0%	4.0%	5.0%	5.0%

% Adjustment Assuming that More than 75 Percent of Eligible Professionals Are Meaningful Users[1]						
	2015	**2016**	**2017**	**2018**	**2019**	**2020+**
EP **is not** subject to the payment adjustment for eRx in 2014	1.0%	2.0%	3.0%	3.0%	3.0%	3.0%
EP **is** subject to the payment adjustment for eRx in 2014	2.0%	2.0%	3.0%	3.0%	3.0%	3.0%

[1]CMS Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Professionals (last updated August 2014), available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf

2015 Stage 1 Core Measures for Medicare EPs

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1. Computerized Provider Order Entry
2. Drug-Drug/Drug-Allergy Interaction Checks
3. Maintain up-to-date problem list
4. Generate and transmit electronic prescriptions
5. Maintain an active medication list
6. Maintain an active allergy list
7. Record language, gender, race, ethnicity, and DOB
8. Record and chart changes in vital signs
9. Record smoking status for patients 13 and older
10. Clinical decision support
11. Allow patients to view, download, transmit health information
12. Provide clinical summaries for patients for each office visit
13. Conduct or review a security risk analysis in accordance with the HIPAA Security Rule

2015 Stage 1 Menu Objectives for Medicare EPs

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1. Submit electronic data to immunization registries
2. Capability to submit electronic syndromic surveillance data
3. Implement drug formulary checks
4. Incorporate clinical lab-test results into CEHRT
5. Generate lists of patients based on their specific conditions
6. Patient reminders for preventative/follow-up care
7. Provide patient-specific education resources
8. Medication reconciliation
9. Provide a summary care record for each transition of care or referral

2015 Stage 2 Core Measures for Medicare EPs

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1. Computerized Provider Order Entry
2. Generate and transmit electronic prescriptions
3. Record language, gender, race, ethnicity, and DOB
4. Record and chart changes in vital signs
5. Record smoking status for patients 13 and older
6. Clinical decision support
7. Allow patients to view, download, transmit health information
8. Provide clinical summaries for patients for each office visit
9. Conduct or review a security risk analysis in accordance with the HIPAA Security Rule
10. Incorporate clinical lab-test results into CEHRT
11. Generate lists of patients based on their specific conditions
12. Patient reminders for preventative/follow-up care
13. Provide patient-specific education resources
14. Medication reconciliation
15. Provide a summary care record for each transition of care or referral
16. Submit electronic data to immunization registries
17. Use secure electronic messaging to communicate with patients

2015 Stage 2 Menu Objectives for Medicare EPs

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1. Capability to submit electronic syndromic surveillance data
2. Record electronic notes in patient records
3. Imaging results accessible through CEHRT
4. Record patient family health history
5. Capability to identify and report cancer cases
6. Capability to identify and report specific cases to a specialized registry other than a cancer registry

2017 Stage 3 Objectives for Medicare EPs

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1. Protect electronic protected health information created or maintained by the CEHRT through the implementation of appropriate safeguards
2. Generate and transmit permissible prescriptions electronically
3. Implement clinical decision support interventions focused on improving performance on high-priority health conditions
4. Use computerized provider order entry for medication, laboratory, and diagnostic imaging orders
5. Provide access for patients to view online, download, and transmit their health information, or retrieve their health information through an API within 24 hours of its availability
6. Use communications functions of certified EHR technology to engage with patients or their authorized representatives about the patient's care
7. Provide a summary of care record when transitioning or referring their patient to another setting of care; Receive summary of care record upon first patient encounter with a new patient and incorporate summary of care record from other providers
8. Active engagement with a public health agency or clinical data repository to submit electronic public health data, except where prohibited by law

2015 CQM Selection

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- As with PQRS, EP must select 9 clinical quality measures across 3 NQS domains
- If reporting as a group practice, and group reports CAHPS for PQRS survey modules, group may report 6 CQMs across 2 of the NQS domains
- For 2014 and 2015, no “core set”, but two recommended core sets of “electronic Clinical Quality Measures” (eCQMs) that meet all program requirements:
  - 9 eCQMs for adult populations
  - 9 eCQMs for pediatric populations

2015 CQM Reporting Options

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- If an EP individually reports CQMs for PQRS and wants to report CQMs once for both PQRS and EHR Incentive Program, EP may report CQMs:
  - Directly from CEHRT
  - Through Data Submission Vendor that is CEHRT (DSV)
  - Via Qualified Clinical Data Registry
- If EP intends to report quality measures for Meaningful Use and PQRS separately, the EP may report CQMs through the EHR Registration and Attestation System

2015 CQM Reporting Options (cont'd)

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- If EPs are reporting CQMs for PQRS as a group and the group wants to report CQMs once for both PQRS and the EHR Incentive Program, the group may report the CQMs:
  - Directly from CEHRT
  - Through a DSV that is CEHRT
  - Through GPRO Web Interface
  - Through Shared Savings Program ACO or Pioneer ACO
- EPs in a group may also report CQMs for the EHR Incentive Program through the EHR Registration and Attestation System (but would also need to separately report quality measures for PQRS)

Common Pitfalls

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- Use of non-CEHRT to achieve Meaningful Use measures
- Use of non-CEHRT to calculate CQMs; CQM data must be produced as output from CEHRT rather than non-certified analytics software
- Failure to complete HIPAA-compliant risk analysis prior to end of the Meaningful Use reporting period
- Aggregation of Meaningful Use measure data for EPs practicing in multiple locations

CQM Reporting Hypothetical

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- An EP adopts CEHRT that is certified as a “Complete EHR”, which means that it has the capability to calculate CQMs and submit them electronically. The EP elects to use a qualified registry rather than CEHRT to calculate and report 9 quality measures to CMS.
  - Has the EP complied with PQRS?
  - Has the EP achieved Meaningful Use?

Hardship Exceptions from Penalties

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- Medicare EPs can apply for hardship exceptions for the following reasons:

1. **Infrastructure** – EPs must demonstrate they are in an area without sufficient internet access or face insurmountable barriers
2. **Unforeseen Circumstances** – Examples may include a natural disaster or lack of available 2014 CEHRT (due to vendor issues and delays during 2014 reporting period)
3. **Practice at Multiple Locations** – Lack of control over availability of CEHRT for more than 50% of patient encounters
4. **Patient Interaction** – Lack of face-to-face or telemedicine interaction with patient

- 2016 EP Hardship Application due to CMS by July 1, 2015 and is available on the CMS website
- The following EPs will be granted an exception from penalties automatically in 2016 and do not need to apply for hardship:

1. **New Eligible Professionals** – Newly practicing EPs will be given a 2-year limited exception to payment adjustments
2. **PECOS Specialties** – Anesthesiologists, Radiologists, and Pathologists

Preparing for a Meaningful Use Audit

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- EPs should retain a report from the CEHRT to validate all Meaningful Use measure numerators and denominators submitted in attestation[1]
- For non-percentage based measures, EPs should retain the following[1]:

Meaningful Use Measure	Audit Validation	Suggested Documentation
Drug-Drug/Drug-Allergy Interaction Checks and Clinical Decision Support	Functionality is available, enabled, and active in the system for the duration of the EHR reporting period.	One or more screenshots from the certified EHR system that are dated during the EHR reporting period selected for attestation.
Report ambulatory or hospital clinical quality measures	**Clinical quality measure data is reported directly from certified EHR systems**	**Report from the certified EHR system to validate all clinical quality measure data entered during attestation.**
Protect Electronic Health Information	Security risk analysis of the certified EHR technology was performed prior to the end of the reporting period	Report that documents the procedures performed during the analysis and the results. Report should be dated prior to the end of the reporting period and should include evidence to support that it was generated for that provider's system (e.g., identified by NPI, CCN, etc.)

[1] EHR Incentive Programs Supporting Documentation for Audits (last updated February 2013), available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_SupportingDocumentation_Audits.pdf

Preparing for a Meaningful Use Audit

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Meaningful Use Measure	Audit Validation	Suggested Documentation
Electronic Exchange of Clinical Information	One test of certified EHR technology's capacity to electronically exchange key clinical information to another provider of care with a distinct certified EHR or other system capable of receiving the information was performed during the EHR reporting period.	• Dated screenshots from EHR system of a test exchange • A dated record of successful or unsuccessful transmission from another system • A letter or email from the receiving provider confirming successful exchange, including specific information
Drug Formulary Checks	Functionality is available, enabled, and active in the system for the duration of the EHR reporting period.	One or more screenshots from the certified EHR system that are dated during the EHR reporting period selected for attestation.
Generate Lists of Patients by Specific Conditions	One report listing patients of the provider with a specific condition.	Report from the certified EHR system that is dated during the EHR reporting period selected for attestation. (Patient data may be masked/blurred)

EHR Incentive Programs Supporting Documentation for Audits (last updated February 2013), available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_SupportingDocumentation_Audits.pdf

Future of EHR Incentive Program

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- Quality Reporting under Stage 3 Proposed Rule
  - CQM requirements for Medicare EPs demonstrating Meaningful Use would be promulgated under the Medicare Physician Fee Schedule Rule rather than under Stage 3 final rule
  - CMS would continue to encourage Medicare EPs to submit CQM data electronically in 2017, and require Medicare EPs to submit CQMs electronically in 2018 where feasible

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April 23, 2015

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