DOCTORS' RESOURCE SPECIALISTS

**"The only place success comes before work is in the dictionary."** – Vince Lombardi

# Client Memo March 2019

***NEWS Updates***



## AMGA Seeks End of MIPS Exclusions to Promote Value-Based Care

**MIPS exclusions mean limited incentives for high-performing medical groups to invest in and implement new health IT**.

The American Medical Group Association (AMGA) is calling on Congress to eliminate the MIPS exclusions that exempted more than half of eligible clinicians, writes Kyle Murphy in the February 5, 2019, issue of *EHR Intelligence.*

The organization representing medical groups drew especial attention to the budget-neutral provision of MACRA that means negative payment adjustments for some become positive payment adjustments for others.

By excluding nearly 60 percent of eligible providers from the pool, the gains for high-performing medical groups were not as significant as planned.

"For example, high performers are estimated to receive an aggregate payment adjustment in 2019 of 1.1%, compared to a potential 4% allowed under the statute," observed Jerry Penso, MD, AMGA President and CEO. "In 2020, CMS expects a 1.5% payment adjustment for high performers, compared to a potential 5% adjustment provided for in the law. In 2021, CMS expects a 2% payment adjustment for high performers, but the statute suggests a potential 7% adjustment."

These insignificant payment updates fail to reward providers for superior performance in the MIPS program and provides a nominal return on investments.

> **"Unfortunately, MIPS has devolved into an expensive regulatory compliance exercise with little to no impact on quality or cost."**

"Unfortunately, MIPS has devolved into an expensive regulatory compliance exercise with little to no impact on quality or cost. Policymakers should no longer exclude providers from MIPS," Penso argued.

AMGA has called on Congress to also lower the threshold for participating in Advanced APMs, the second path of the Quality Payment Program and the goal of MACRA as far as tying payments to value.

"To qualify for the program, providers must meet or exceed minimum revenue thresholds from APMs, or minimum numbers of Medicare beneficiaries in these models," wrote Penso. "For example, in 2019, 25% of a provider's Medicare revenue must come from APMs. In 2021, 50% of revenue must come from APMs. This threshold increases to 75% in 2023." According to AMGA, this approach is unlikely to meet with success.

Also tied to MIPS and APMs is the matter of data access, which AMGA has identified as a pain point for medical groups.

AGMA has also identified the need for greater data standardization to ensure that providers avoid the wasting of time and resources preparing data sets for analysis and interpretation.

## MIPS Facility-Based Measurement

Beginning with 2019, providers can choose to use a facility-based scoring option for the MIPS quality and cost performance categories. CMS will identify which providers and groups are eligible for facility-based measurement.

Eligible providers would automatically have these scores added to their Improvement Activities and Promoting Interoperability performance categories, if applicable, to reach their final MIPS score.

If the provider reports on quality measures using another method such as claims submission, CMS will assign the higher score.

Molly MacHarris, a MIPS program lead for CMS, addresses facility-based measurement as part of her power point presentation "Quality Payment Program Year 3 (2019) Final Rule Overview."

**Applicability**

- The eligible clinician must furnish 75% or more of his or her covered professional services in an in-patient hospital (POS 21), an on-campus outpatient hospital (POS 22), or an emergency room (POS 23), based on claims for a period prior to the performance period.
- The clinician must have at least one service billed with the POS code used for inpatient hospital or emergency room.
- A facility-based group is defined as one in which 75% or more of the MIPS eligible clinicians billing under the group's TIN are eligible for facility-based measurement as individuals.

**Attribution**

- A facility-based clinician would be attributed to the hospital where they provide services to the most patients while a facility-based group would be attributed to the hospital to which most facility-based clinicians are attributed.
- If a facility with a Hospital Value-based Purchasing (VBP) score can't be identified, that clinician would not be eligible.

**Election**

- The facility-based measurement will be automatically applied for clinicians and groups who are eligible and who would benefit by having a higher combined Quality and Cost score.
- No submission requirements exist for individual clinicians in facility-based measurement, but a group would need to submit data for the Improvement Activities or Promoting Interoperability performance categories in order to be measured as a facility-based group.

**Measurement** -- For facility-based measurement, the measure set for the fiscal year Hospital VBP Program that begins during the applicable MIPS performance period would be used for facility-based clinicians.

**Assigning MIPS Category Scores**

- The Quality and Cost performance category scores (which are separate scores) for facility-based clinicians are based on how well the clinician's hospital performs in comparison to other hospitals in the Hospital VBP Program.
- Some hospitals do not receive a Total Performance Score in a given year in the Hospital VBP Program. In these cases, facility-based clinicians would be required to participate in MIPS via another method.

## Updated MIPS Quality Measures

Listed below are some of the new and updated MIPS Quality measures for 2019:

**New Quality Measures:**

#468 Continuity of Pharmacotherapy for Opioid Use Disorder
#469 Average Change in Functional Status Following Lumbar Spine Fusion Surgery
#470 Average Change in Functional Status Following Total Knee Replacement Surgery
#472 Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture
#474 Zoster (Shingles) Vaccination
#475 HIV Screening

**Quality Measures Finalized for Removal**

#18 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
#99 Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
#122 Adult Kidney Disease: Blood Pressure Management
#140 Age-Related Macular Degeneration: Counseling on Antioxidant Supplement
#163 Comprehensive Diabetes Care: Foot Exam
#204 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
#276 Sleep Apnea: Assessment of Sleep Symptoms
#278 Sleep Apnea: Positive Airway Pressure Therapy Prescribed
#334 Adult Sinusitis: More than One CT Scan Within 90 Days for Chronic Sinusitis (Overuse)
#367 Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use
#373 Hypertension: Improvement in Blood Pressure
#447 Chlamydia Screening and Follow-up

**Quality Measures with Changes**

#117 Diabetes: Eye Exam
#128 Preventive Care and Screening: BMI Screening and Follow-Up Plan
#176 Rheumatoid Arthritis: Tuberculosis Screening
#177 Rheumatoid Arthritis: Periodic Assessment of Disease Activity

#220 Functional Status Change for Patients with Low Back Impairments
#370 Depression Remission at Twelve Months
#371 Depression Utilization of the PHQ-9 Tool
#410 Psoriasis: Clinical Response to Systemic Medications
#419 Overuse of Imaging for the Evaluation of Primary Headache

**The above is just a representative sample. For a full list of measures including reporting requirements please go to Appendix 1 of the Federal Register:**

https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf

## Security Risk Assessment Reminder

**Protecting patient health information** is a base score measure and an integral part of the MIPS Promoting Interoperability performance category. A security risk analysis must be completed and properly documented.

Under the HIPAA Security Rule, eligible clinicians are required to conduct an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI) held by the covered entity or business associate.

--Medaxiom

Completing a comprehensive security risk assessment has been purported to be the most audited measure. MIPS and Meaningful Use security audits are actively being conducted by Figliozzi and Company on a pre- and post-payment basis, and several practices have forfeited large sums of incentive payments by failing to produce supporting documentation.

To meet this measure, MIPS eligible clinicians must attest "YES" to conducting or reviewing a security risk analysis, implementing security updates as necessary and correcting identified security deficiencies.

Clicking the yes button is easy to do but don't forget to have a completed analysis for the performance year on file.

The parameters of the security risk analysis are defined by 45 CFR 164.308(a)(1), which is part of the HIPAA Security Rule. More information on the HIPAA Security Rule can be found at:
http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule

## MIPS Improvement Activities

The MIPS Improvement Activities performance category measures an eligible clinician's participation in activities that improve clinical practice, such as:

- Ongoing care coordination
- Clinician and patient shared decision making
- Regularly using patient safety practices
- Expanding practice access
- Population management

CMS has released Data Validation Criteria which outlines documentation guidelines for Improvement Activities as well as for Quality and Promoting Interoperability measures.

Documentation suggestions for three high-weighted Improvement Activities are:

| Activity | Suggested Documentation |
|---|---|
| **Provide 24/7 access to eligible clinician or groups who have real-time access to patient's medical record** | Patient record in the EHR shows:<br>1. date and timestamp to indicate services were provided outside of normal business hours;<br>2. the patient encounter/medical record/ claim indicates the patient was seen or services were provided outside of normal business hours; or<br>3. the patient encounter/medical record/ claim indicates patient was seen same-day or next- day for urgent or transitional care. |
| **Consultation of the Prescription Drug Monitoring program** | 1. Indicate total number of issuances of a CSII Rx that lasts longer than 3 days over the same time period as those consulted;<br>2. Documentation of the total number of patients for whom there is evidence of consulting the PDMP prior to issuing a CSII Rx. |
| **Engagement of new Medicaid patients and follow-up** | 1. Timely Appointments for Medicaid and Dually Eligible Medicaid/Medicare Pts -- Data from certified EHR or scheduling systems (may be manual) on time from request for appointment to first appointment offered or appointment made by type of visit; and<br>2. Appointment Improvement Activities – Assessment of new and follow-up visit appointment statistics to identify and implement improvement activities |

The full list of documentation recommendations for Improvement Activities can be found at:
http://www.ascrs.org/sites/default/files/Remediated%20MIPS%20Data%20Validation%20Criteria%202017%2004%2024.pdf

## CMS Proposes to Modernize Medicare Advantage, Expand Telehealth Access for Patients – *CMS Newsroom*, October 26, 2018

In a proposed rule issued October 26, 2018, CMS took action to build upon the Administration's ongoing efforts to modernize the Medicare Advantage and Part D programs. The proposed changes would allow Medicare Advantage plans to cover additional telehealth benefits and make other much-needed updates.

With respect to telehealth, the proposed changes would remove barriers and allow Medicare Advantage plans to offer "additional telehealth benefits," not otherwise available in Medicare, to enrollees, starting in plan year 2020 as part of the government-funded "basic benefits."

The proposal would give Medicare Advantage plans more flexibility to offer government-funded telehealth benefits to all their enrollees, whether they live in rural or urban areas. It would also allow greater ability for Medicare Advantage enrollees to receive telehealth from places like their homes, rather than requiring them to go to a health care facility to receive telehealth services.

While Medicare Advantage plans have always been able to offer more telehealth services than are currently payable under original Medicare through supplemental benefits, this change in how such additional telehealth benefits are financed (that is, accounted for in payments to plans) makes it more likely that Medicare Advantage plans will offer them and that more enrollees will be able to use the benefits.


Additional proposed changes would improve the quality of care for dually-enrolled beneficiaries in Medicare and Medicaid who participate in "Dual Eligible Special Needs Plans" or D-SNPs. These beneficiaries generally have complex health needs. The proposed rule would also require plans to more seamlessly integrate benefits across the two programs to promote coordination.

The proposed changes would update the methodology for calculating **Star Ratings** which provide information to consumers on plan quality. The new methodology would improve stability and predictability for plans, and would adjust how the ratings are set in the event of extreme and uncontrollable events such as hurricanes.

The proposed rule also includes critical updates with respect to program integrity:

1. CMS is making revisions to an earlier regulation that made available to Part D sponsors and Medicare Advantage plans a list of precluded providers and prescribers that have engaged in behavior that bars their enrollment in Medicare.

2. The proposed rule would take steps to help CMS recover improper payments made to Medicare Advantage organizations.

## Spear phishing: A New Cyber Threat

What is Spear Phishing: an email or electronic communications scam targeted towards a specific individual, organization or business.

You are alerted to a new email from what looks like a well-known insurance company, complete with a recognizable logo. The email refers to you and your office manager by name and informs you that you can clear up your reimbursement issues if you just click a link and provide some extra information. What do you do? Kayt Sukel asks in her February 6, 2019, article for *Medical Economics*.

Many healthcare professionals would click without a second thought. In doing so, they might very well be inviting a hacker into their networks via a sophisticated electronic communications scam called spear phishing, she writes.

**Spearfishing is a more sophisticated form of phishing, targeting a specific organization or individual.**

These personalized attacks are on the rise in healthcare and can have serious consequences for organizations of all shapes and sizes.

"With phishing, the hacker doesn't necessarily care who clicks, he or she is casting a wide net in hopes of getting someone to do so, "says Parham Eftekhari, executive director of the Institute for Critical Infrastructure Technology, a cybersecurity think tank. "But spear-phishing uses a tailored lure -- a spear, so to speak -- to make the email with those links more appealing to a specific victim."

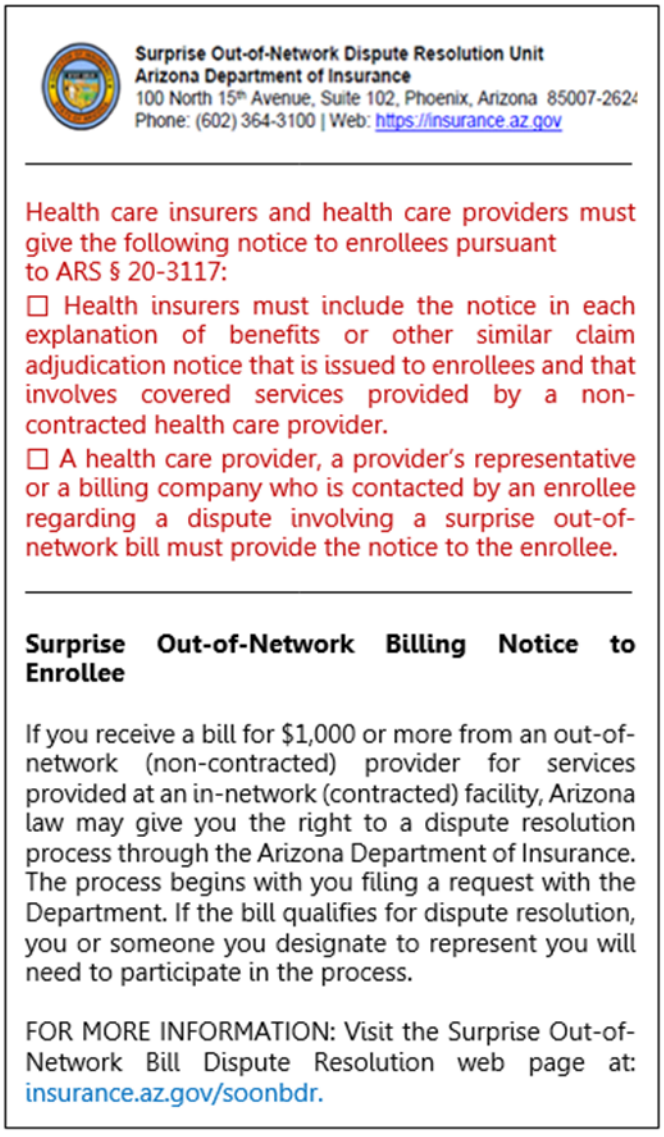
In a recent AMA survey, 4 out of 5 survey respondents said they had been the target of a cyberattack, with more than half of those stating the attack was the result of a phishing lure.

The AMA has published specific cybersecurity guidelines for physicians on its website to promote proper cyber hygiene. It also recommends that physicians familiarize themselves with cybersecurity recommendations offered by the Department of Homeland Security.

But most importantly, physicians and clinical staff need to slow down and think before they click. All it takes is one person to click on the wrong link to result in a breach.

## Arizona's Surprise Billing Law

Arizona has joined other states like New York and California by passing a law to protect patients from surprise medical bills. The new law took effect on January 1, 2019.



**Surprise Out-of-Network Dispute Resolution Unit**
**Arizona Department of Insurance**
100 North 15th Avenue, Suite 102, Phoenix, Arizona 85007-2624
Phone: (602) 364-3100 | Web: https://insurance.az.gov

Health care insurers and health care providers must give the following notice to enrollees pursuant to ARS § 20-3117:

☐ Health insurers must include the notice in each explanation of benefits or other similar claim adjudication notice that is issued to enrollees and that involves covered services provided by a non-contracted health care provider.

☐ A health care provider, a provider's representative or a billing company who is contacted by an enrollee regarding a dispute involving a surprise out-of-network bill must provide the notice to the enrollee.

**Surprise Out-of-Network Billing Notice to Enrollee**

If you receive a bill for $1,000 or more from an out-of-network (non-contracted) provider for services provided at an in-network (contracted) facility, Arizona law may give you the right to a dispute resolution process through the Arizona Department of Insurance. The process begins with you filing a request with the Department. If the bill qualifies for dispute resolution, you or someone you designate to represent you will need to participate in the process.

FOR MORE INFORMATION: Visit the Surprise Out-of-Network Bill Dispute Resolution web page at: insurance.az.gov/soonbdr.

The law's aim is to protect patients from receiving a surprise out-of-network bill. These bills occur when a patient receives care at an in-network facility, but the doctor is not in their insurance provider's network.

The law, which updates a 2017 measure, allows patients who received a surprise out-of-network bill to seek a dispute resolution by submitting a request through the Arizona Department of Insurance. When a complaint qualifies as a surprise out-of-network bill, the department of insurance will help schedule an informal settlement conference involving the insurer, the medical provider and the patient, the report states. Arbitration would be the next step if an agreement is not reached.

There are, however, some significant exceptions:

- Health care services were received on or after January 1, 2019;
- The disputed bill must be at least $1,000;
- The law does not apply to anyone enrolled in an HMO;
- Patients can dispute the charge ONLY if they have **not** been informed, ahead of time and in writing that certain specific services will be provided by an out-of-network doctor and the estimated total costs to be billed.

Patients, health providers, and insurers each have their own forms that need to be completed. To obtain the necessary forms and instructions, please contact: soonbdr@azinsurance.gov or call 602-364-2399.

On the **federal level,** a bipartisan group of senators from both sides of the aisle have requested information from providers and payers regarding surprise medical billing.

In a recently released letter, health plans were asked to provide details on what they currently pay for out-of-network care on average, broken down by plan type, market type, and provider type, writes Jessica Kent in her article "Senators Request Payer, Provider Data on Surprise Medical Billing" for *Health Payer Intelligence,* February 13, 2019.

The lawmakers also requested information on how these rates compare to Medicare rates, average in-network rates, and provider charges.

Health plans were asked whether they have a process for identifying when providers send balance bills, and what percentage of these balance bills exceed $750.

Regarding providers, the senators also wanted to know the average out-of-network payment that they receive for emergency services, and how this compares to Medicare, broken down by plan type and market.

In addition, the letter asks providers for data to show how often a balance bill is sent to a patient in situations where the ED or ancillary provider is out-of-network, but the facility is in-network. This letter builds on ongoing Senate efforts to increase price transparency and reduce health-care costs.

## Deadline for Electronic Prescribing of Opioids Extended

On February 14, 2019, Governor Ducey signed HB 2075 which extends the deadline for electronic prescribing of controlled substances to January 1, 2020 for all Arizona counties. The bill also eliminates language from the Arizona Opioid Epidemic Act allowing the Arizona Board of Pharmacy to grant a waiver for the electronic prescribing requirement.

The Arizona Board of Pharmacy received and granted more than 40,000 waivers to the electronic prescribing requirement. The removal of the waiver sets a level playing field for all Arizona providers, according to Connie Ihde, Health Current's Director of Programs who has led Health Current's Click for Control campaign aimed at assisting Arizona providers in becoming ready for EPCS.

**All Arizona providers must become EPCS-ready by January 1, 2020.**

# MEDICARE NEWS

### MIPS: Check Your Preliminary 2019 Eligibility

Check the Quality Payment Program Participation Status Tool to view your eligibility status for the 2019 performance period under MIPS. Enter your individual NPI number to find out if you need to participate in MIPS during the 2019 performance year.

Please go to https://qpp.cms.gov and click on the check participation button. Type in your Individual NPI number to view your status.

### 1099s Available on the Noridian Medicare Portal

It's tax time and Noridian can help you out. The 2018 1099-INT and/or 1099-MISC are now available on the Noridian Medicare Portal (NMP). The 1099 inquiry is available through the Financials function.

1099s on the portal are copies of the official 1099 forms that were mailed. View the "1099 Inquiry" section of the NMP User Manual on your Jurisdictions website to download your copy today.

For Jurisdiction F – Medicare Part B (Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming), copy and paste the following:

https://med.noridianmedicare.com/web/jfb/topics/nmp/end-user-manual

### MIPS Attestation Timeline

The MIPS submission window is currently open through April 2, 2019, 8 pm EDT. Sign in to submit and update your data for 2018. The CMS Web Interface submission period ends on March 22, 2019 at 8 pm EDT.

Please note that registries will have their own specific deadlines for submitting data; for example, MIPS Wizard's deadline is 3/31/19.

Preliminary performance feedback reports will be available April 3, 2019. Final performance reports will be available around July 1, 2019.

***We are working hard to keep you on the edge of healthcare. Help us fulfill our strong commitment to maintain our level of service excellence by providing us with your feedback. Please feel free to contact Sue or Julie at 1.877.845.2969.***

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Susan Magalnick or Julie Serbin @ DRS 1.877.845.2969

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