Coker GROUP

Business Advisors for the Healthcare Industry

One Month Into MACRA

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Today's Agenda

- Volume to Value Review and Update
- 2019 Medicare Physician Fee Schedule Changes
- Prepare Your Practice
- Compliance Concerns in the New World

VOLUME TO VALUE REVIEW AND UPDATE

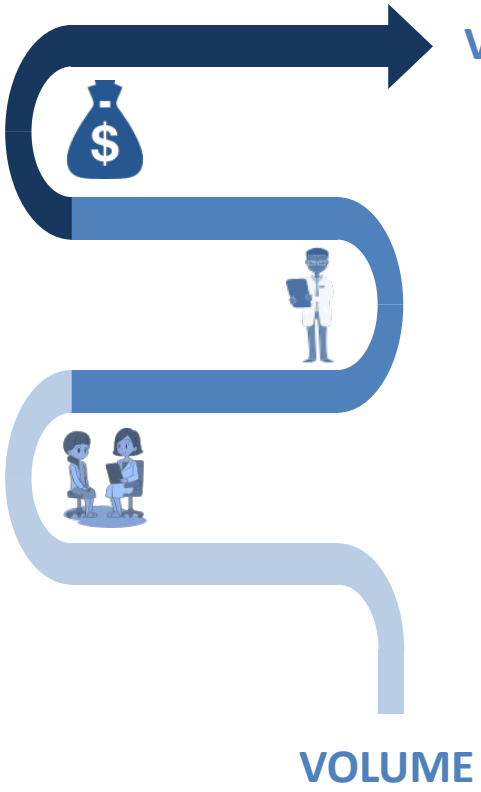
Industry Paradigm Shifts

Payers

- Risk shifting from payers to providers (both upside and downside risk based upon outcomes)
- Increasing number of value-based programs (i.e., bundled payments, pay-for-performance, shared savings plans, etc.)

Patients

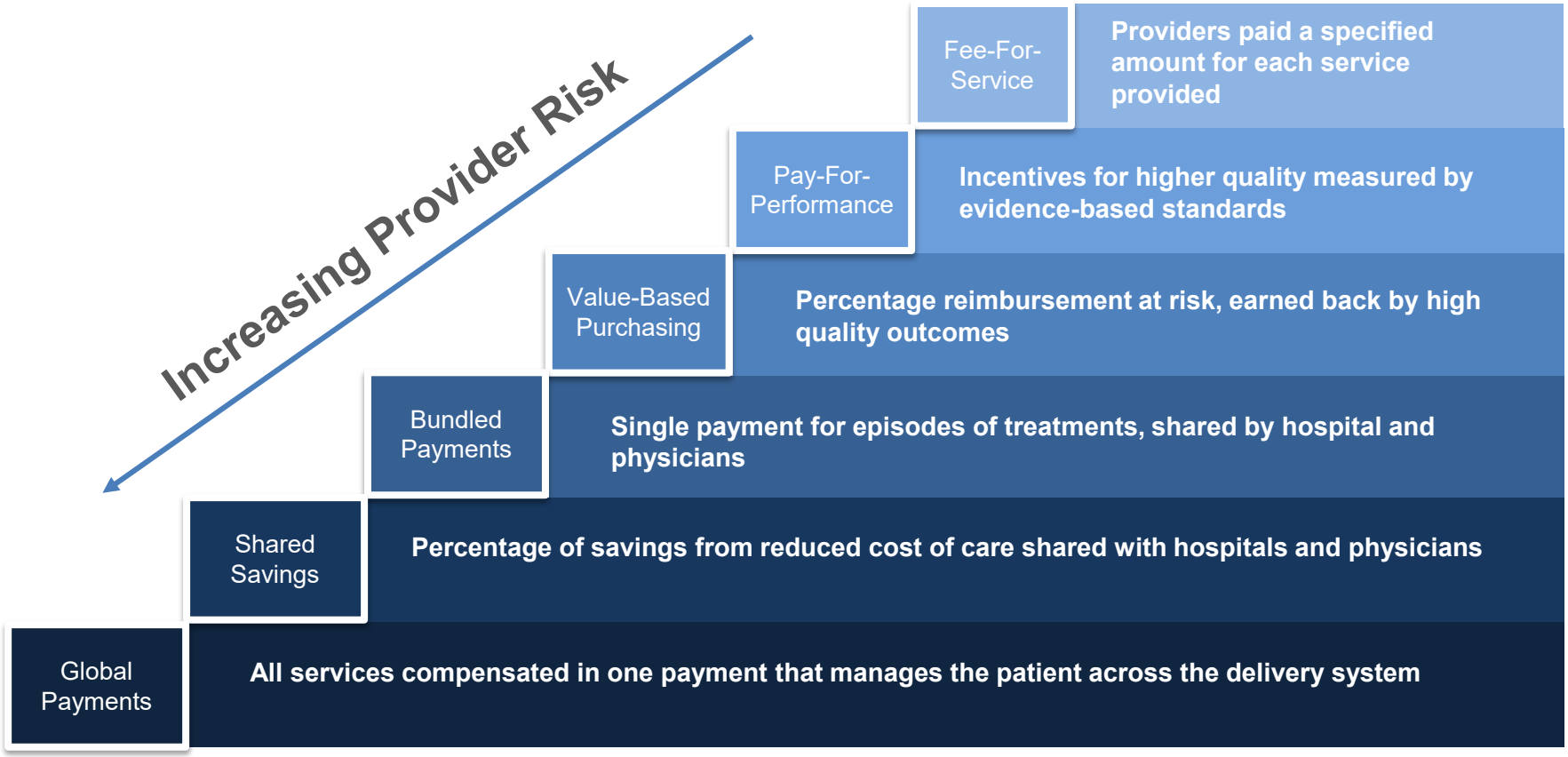
- Consumer-driven, high deductible health plans with increasing price transparency



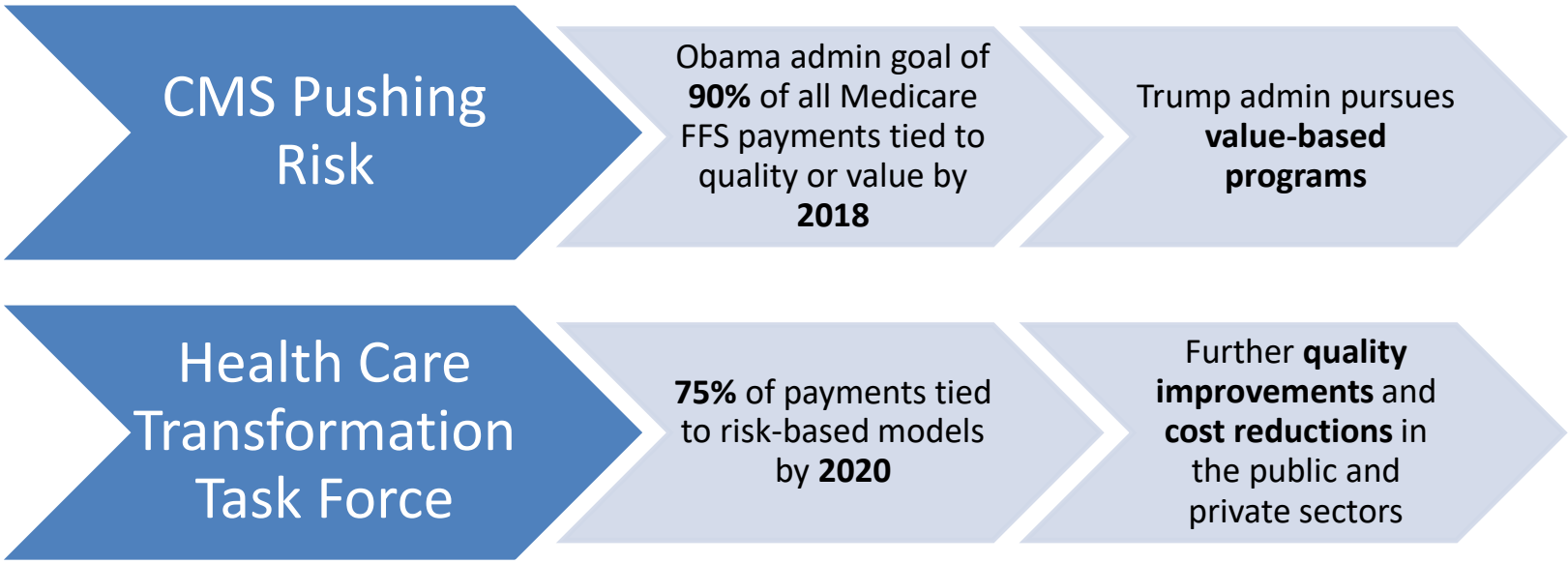
Providers

- Re-tooling operations to infuse more focus on care management, cost reduction, data utilization and prevention/overall wellness
- Harnessing innovation and entrepreneurialism (particularly for independent providers) to develop clinically integrated networks (CINs) that are private practice or ASC based

Changing Payment Models



Overarching Payer Goals



Sources: http://hcttf.org/about-us/guiding-principles/

Transition to Value

In an effort to reduce costs and increase quality of care, the U.S. government began to transition to value-based reimbursement with the passage of the Affordable Care Act ("ACA") and Medicare Access and CHIP Reauthorization Act ("MACRA"):

ACA

- Established the Medicare Shared Savings Program, which allows for VBR through accountable care organizations ("ACOs").
- Mandated the initiation of various pilot projects that test alternative payments systems such as the implementation of bundled payments.

MACRA

- Established MIPS, which scores providers on various quality and cost-based categories.
- MIPS providers' performance will be judged against their peers, and they will be eligible for a 4% Medicare Part B payment adjustment increase in 2019, and a 9% increase in 2022.

2017 QPP Outcomes

- More than 1 million clinicians participated in the QPP for this year
- Almost 100,000 clinicians earned APM participant status
- The overall mean score for MIPS-eligible physicians was 74.01 points; the median 83.04
- Scores were higher for those participating in MIPS through an APM
- Small and rural practice participants earned lower scores
  - Rural – mean score 63.08
  - Small practices – mean score 43.36
- The majority of MIPS participants (93%) received a positive payment adjustment (maximum 1.88%)
- 71% of clinicians earned a positive payment adjustment and a bonus for exceptional performance
- 2% of clinicians had a neutral (or no change) adjustment
- 5% of clinicians received a negative payment adjustment (maximum -4%)

Source: https://www.beckershospitalreview.com/finance/95-of-physicians-avoid-mips-penalties-12-notes-on-qpp-year-1.html

2019 MEDICARE PHYSICIAN FEE SCHEDULE CHANGES

2019 Medicare PFS Changes

Summary of Changes to the 2019 Medicare Physician Fee Schedule (PFS)

- MACRA required a 0.25% PFS payment increase from 2018, and the conversion factor increased to $36.04 from $35.99 in 2018
- CMS delayed the proposed billing code collapse for levels 2 through 4 until 2021
- Providers are now able to bill separately for virtual communication with patients such as telehealth visits or reviewing photos and videos
- Providers will not be required to enter redundant information already documented in medical records that has not changed
- Revised the interoperability performance category of the Merit-based Incentive Payment System (MIPS)
  - Adjusted the scoring methodology and measures to focus on EHR interoperability
  - Increased the MIPS cost category weighting from 10% to 15% and reduced the weight of the quality category from 50% to 45%
    - Categories for promoting interoperability (25%) and improvement activities (15%) did not change
  - Expanded QPP eligibility to include more provider types as well as established an “opt-in” process for providers that do not meet previous volume requirements

Takeaway: CMS is committed to reducing administrative and documentation burdens so providers can focus on quality and patient care, both in-person or in a virtual setting

Catching Up with Care Delivery

CMS is taking a step in the right direction to improve access to care and more appropriately compensate physicians and health systems for their work

New 2019 Codes	Code Description	CY19 wRVUs	CY19 Approx. Payment	Consent Required?	Key Details / Considerations
G2010	Remote evaluation of recorded video and/or images by est. patient including interpretation and follow up	0.18	$12.61	Yes - may be documented in chart	(1) Provider follow-up within 24 business hours (via phone, secure messaging, email) (2) Service should not originate from E/M within previous 7 days (3) Service should not lead to a visit with the provider within 24 hours or "soonest available appt." (4) Co-pay may apply (5) Established patients only (6) No frequency limit
G2012	Brief virtual check-in by physician or qualified health professional	0.25	$14.78	Yes - may be documented in chart	(1) May include telephone interactions or secure video conference technology; must involve billing provider (2) 5-10 min. of medical discussion (3) Service should not originate from E/M within previous 7 days (4) Service should not lead to a visit with the provider within 24 hours or 'soonest available appt.' (5) Co-pay may apply depending on insurance (6) Established patients only (7) No frequency limit

Two new G-Codes more appropriately reflect provider efforts for conducting virtual check-in visits and remote evaluation of pre-recorded patient information

Catching Up with Care Delivery

CY19 fee schedule changes recognize advances in communication technology and its significant role in the modern patient-provider relationship

- The CY19 rule implemented codes for Interprofessional Internet Consultations as well as Chronic Care Remote Physiologic Monitoring
- Introducing these new codes is a clear indication that CMS has taken provider, patient, and health system feedback regarding “telehealth services” seriously

The Final Rule also created new E/M documentation guidelines to streamline payment and potentially reduce clinician burden

- For established patient visits, document only what has changed since the last visit, or on pertinent items that have not changed
- For new and established patient visits, no need to re-enter the patient’s chief complaint and history when they have already been entered by ancillary staff
- Teaching physicians are no longer required to duplicate notations in the medical record that may have previously been documented by residents or other members of the medical team

Prepare Your Practice

Know the Rules, Limit Risk, and Maximize Reimbursement

- Evaluate your practice's coding distribution and reimbursement data to estimate and analyze the impact of 2019 changes as well as anticipated changes in 2021
- Conduct coding analysis to identify opportunities for education and training to take advantage of new codes in 2019
- Adjust provider documentation protocols according to new guidelines to save provider time – provide ongoing education, template redesign
- Consider adjusting operations and/or service offerings (e.g. telehealth) to maximize reimbursement under new coding and documentation guidelines
- Fine tune revenue cycle processes and protocols
- Proactively prepare for potential reimbursement rate compression in 2021:
  - Reinforce coding/chart review and audit processes
  - Provide consistent coding and documentation training for providers and staff

These new and pending changes present an opportunity to *IMPROVE* reimbursement, but it requires a proactive plan to adapt

COMPLIANCE CONCERNS IN THE NEW WORLD

Recent OCR Resolutions

Feb 18

- Fresenius Medical Care North America (FMCNA) agreed - **$3.5 million**
- Paid the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR), and to adopt a comprehensive corrective action plan, in order to settle potential violations of HIPAA Privacy and Security Rules
- OCR's investigation revealed FMCNA covered entities failed to conduct an accurate and thorough risk analysis of potential risks and vulnerabilities to the confidentiality, integrity, and availability of all of its ePHI

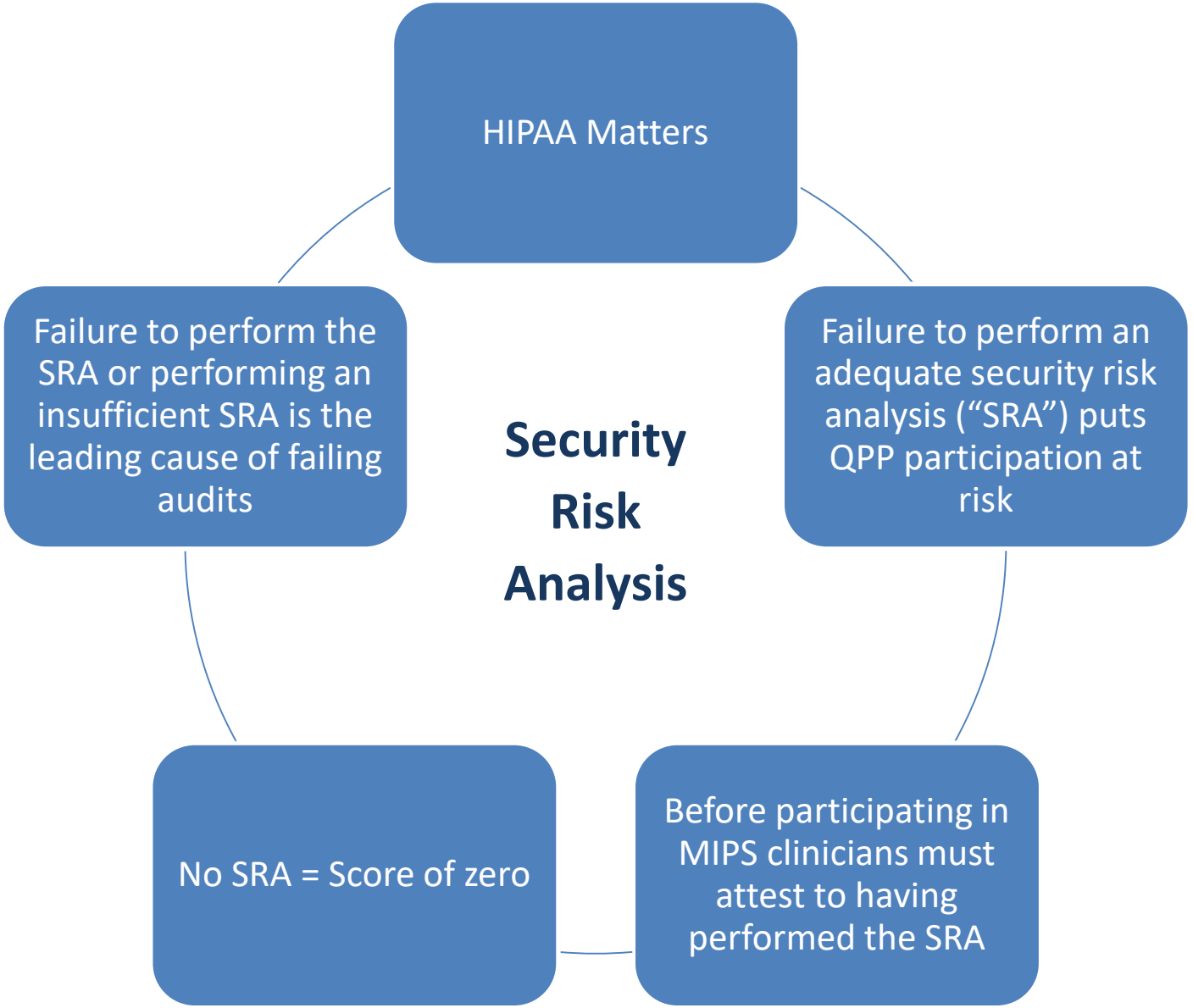
Oct 18

- Anthem pays OCR a record **$16M** HIPAA settlement following largest U.S. health data breach in history
- In addition to the impermissible disclosure of ePHI, OCR's investigation revealed that Anthem failed to conduct an enterprise-wide risk analysis

Dec 18

- Advanced Care Hospitalists (ACH) - **$500,000**
- OCR's investigation revealed that ACH never entered into a business associate agreement with the individual providing medical billing services to ACH, as required by HIPAA and failed to adopt any policy requiring business associate agreements until April 2014
- Although ACH had been in operation since 2005, it had not conducted a risk analysis or implemented security measures or any other written HIPAA policies or procedures before 2014

Security Risk Analysis



SRA Timing

- Must be conducted within the calendar year of the MIPS performance period (January 1st – December 31st)
- It is acceptable for the security risk analysis to be conducted outside the performance period; however, the analysis must be unique for each performance period and the scope must include the full MIPS performance period.
- An analysis must be done upon installation or upgrade to a new system and a review must be conducted covering each MIPS performance period.
- Any security updates and deficiencies that are identified should be included in the clinician's risk management process and implemented or corrected as dictated by that process.
- At minimum, MIPS eligible clinicians should be able to show a plan for correcting or mitigating deficiencies and that steps are being taken to implement that plan.

Information Blocking

- HIPAA
- 21st Century Cures Act of 2016
  - Defined as a practice that is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information
  - Penalties of up to $1 million per violation

Information Blocking (Continued)

- Under the Promoting Interoperability Section

- Must attest to no information blocking via 3 statements
  - Did not knowingly or willfully take action to restrict the compatibility or interoperability of CEHRT
  - Implemented technologies, standards, policies, practices and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the CEHRT was at all relevant times:
    - Connected in accordance with law;
    - Compliant with applicable information exchange standards;
    - Implemented in a manner to permit timely access by patients/other providers; and
    - Implemented in a manner to permit bi-directional exchange with other exchanges/providers (even unaffiliated).
  - Responded in good faith and in a timely manner to patient/provider requests to retrieve or exchange electronic health information

- Examples of information blocking:
  - Fees that make data exchange cost prohibitive
  - Organizational policies or contract terms that prevent sharing information with patients or health care providers
  - Technology designed or implemented in non-standard ways that inhibit the exchange of information
  - Patients or health care providers "locked in" to a specific technology or health care network because data is not portable

***Some actions that impede the exchange of electronic health information do not constitute information blocking. For example, when an act or course of action is necessary to protect patient safety, privacy, or other compelling interests.

Data Validation

- CMS conducts data validation audits on select MIPS eligible clinicians annually
- Must respond within ten (10) days of a request
- Must provide substantive primary source documents
  - Copies of claims, applicable medical records, or other resources used in the data calculations for MIPS measures, objectives and activities
- Inaccurate data submitted on audit could result in recoupment of overpayments
- Ten year record retention period

Contact Information

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