The Impact of Changing Federal Policies on Physician Reimbursement

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Federal Quality Improvement Mandates: The Gathering Storm

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Federal Programs

- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier (VBPM)
- Electronic Health Record (EHR) Incentive Program
Medicare Quality Payment Adjustments

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
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<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PQRS</strong></td>
<td>Bonus</td>
<td>Penalty</td>
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</tr>
<tr>
<td>2013</td>
<td>+0.5%</td>
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<td><strong>PQRS MOC</strong></td>
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<td>-2.0% (based on 2012/2013)</td>
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</tr>
<tr>
<td><strong>eRx</strong></td>
<td>+0.5%</td>
<td>-1.5% (based on 2011/2012)</td>
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<td>TBD</td>
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A Program of The AGA Institute
Physician Quality Reporting System (PQRS)
Physician Quality Reporting System

- Payment adjustments based on reporting of quality measures data for Medicare Part B patients to CMS

- Multiple reporting options
  - Individual level or group practice level (GPRO)
  - Individual measures, measures groups
  - Claims-based, qualified registry, EHR, qualified clinical data registry *(new for 2014)*

- Minimum reporting criteria to avoid penalties $\Rightarrow$ higher criteria to earn incentives

- There’s still time to take action for 2013

  ✓ Earn 0.5% incentive in 2013   ✓ Avoid 1.5% penalty in 2015
Digestive Health Recognition Program

- AGA program that allows you to report for PQRS and earn incentives/avoid penalties
- AGA submits your data to CMS for you
- Report on 20 or more unique patients, a majority of whom (11+) must be Medicare Part B FFS patients
- Report one measures group (either IBD or HCV)

***March 13, 2014, submission deadline***
# Measures Groups

## IBD

<table>
<thead>
<tr>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBD Type, Anatomic Location, Disease Activity, and External Manifestations Assessed</td>
</tr>
<tr>
<td>Corticosteroid-Sparing Therapy Prescribed</td>
</tr>
<tr>
<td>Bone Loss Assessment for Patients Receiving Corticosteroid Therapy</td>
</tr>
<tr>
<td>Testing for latent TB before initiating anti-TNF therapy</td>
</tr>
<tr>
<td>Assessment of hepatitis B virus before initiating anti-TNF therapy</td>
</tr>
<tr>
<td>Influenza Immunization</td>
</tr>
<tr>
<td>Pneumococcal Immunization</td>
</tr>
<tr>
<td>Tobacco Screening and Cessation Counseling</td>
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</tbody>
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## HCV

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<tr>
<td>HCV Ribonucleic Acid (RNA) Testing Before Initiating Treatment</td>
</tr>
<tr>
<td>HCV Genotype Testing Prior to Treatment</td>
</tr>
<tr>
<td>Antiviral Treatment Prescribed</td>
</tr>
<tr>
<td>HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment</td>
</tr>
<tr>
<td>Counseling Regarding Risk of Alcohol Consumption</td>
</tr>
<tr>
<td>Counseling Regarding Use of Contraception Prior to Antiviral Therapy</td>
</tr>
<tr>
<td>Hepatitis A Vaccination in Patients with HCV</td>
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<tr>
<td>Hepatitis B Vaccination in Patients with HCV</td>
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<tr>
<td>Discontinuation of Antiviral Therapy for Inadequate Viral Response</td>
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<tr>
<td>Sustained Virological Response</td>
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<tr>
<td>Body Mass Index (BMI) Screening and Follow-Up</td>
</tr>
</tbody>
</table>
Requirements for 2014 PQRS
✓ Earn 0.5% incentive in 2014
✓ Avoid 2.0% penalty in 2016

Measures groups: Report on either the IBD or HCV measures groups for 20 or more unique patients, a majority of whom (11+) must be Medicare Part B FFS patients

***March 2015 submission deadline***
How Do I Get Started with PQRS?

• Visit www.agarecognition.org
  – Review policies and procedures
  – Review data collection form
  – Register and pay fees ($300 for AGA members per disease state — IBD or HCV)

• Tech support available via website

• Training and content questions available by contacting recognition@gastro.org
Physician Value-Based Payment Modifier (VBPM)
Value-Based Payment Modifier

• ACA mandated that CMS apply a value modifier under the Medicare Physician Fee Schedule
• Assesses both quality AND cost of care
• Linked to PQRS participation
• Phased roll-out
  – 2015 payment (2013 reporting): large group practices of 100+ eligible professionals (EPs)
  – 2016 payment (2014 reporting): small groups of 10+ EPs
  – 2017 payment (2015 reporting): all physicians
2015 Value-Based Payment Modifier

Groups with 100+ EPs

PQRS Reporters in 2013
- Quality tiering election
  *voluntary
  +/- or neutral adjustment based on performance
  max -1.0% if low quality/high cost

Non-PQRS Reporters in 2013
- No election

-1.0%
(+ -1.5% PQRS = -2.5%)
2016 Value-Based Payment Modifier

Groups with **10+ EPs**

- **PQRS Reporters in 2014**
  - Groups with **10+ EPs**
    - + or neutral adjustment
  - Groups with **100+ EPs**
    - +/- or neutral adjustment
      - max -2.0%
- **Non- PQRS Reporters in 2014**
  - -2.0%
    - (+ -2.0% PQRS = - 4.0%)

**Quality tiering**
*mandatory*

**New 50% rule**
Quality and Resource Use Reports (QRUR)

• Annual reports that provide groups of physicians with:
  – Comparative information about the quality and cost of care furnished to their Medicare FFS patients
  – Beneficiary-specific information to help coordinate and improve the quality and efficiency of care furnished
  – Information on how the group would fare under the VBM

• **Fall 2013**: 2012 QRURs made available to all groups of physicians with 25+ EPs

• **Late Summer 2014**: QRURs for all groups and solo practitioners
How to Access QRUR Reports

1. Navigate the Portal
   - Go to https://portal.cms.gov

2. Login to the Portal
   - Select Login to CMS Secure Portal
   - Accept the Terms and Conditions and enter your IACS User ID and Password to login

3. Enter the Portal
   - Click the PV-PQRS tab, and select the QRUR-Reports option
How to Access QRUR Reports

4. Complete Role Attestation
   • Choose the applicable option to complete your request access (“I plan to use this data in my capacity as a...”)

5. Navigate to the Folders Report
   • Choose your QRUR or drill-down report from the applicable reports folder

6. Select Your Medical Group Practice
   • After the report opens, select a Medical Group Practice and click Run Document
Reviewing Your QRUR

• Verify accuracy of EPs billing under your group’s TIN during 2012
• Determine how your group would fare under the VBPM (“performance highlights”)
• Examine the number of beneficiaries attributed to your group and the basis for their attribution
• Evaluate how your group’s performance on quality and cost measures compares to other groups
• Understand which attributed beneficiaries are driving your group’s cost and quality measures
• Identify those beneficiaries that are in need of greater care coordination
2016 VBPM Timeline

1st Quarter
Complete submission of 2014 PQRS data

Jan. 1
VBPM applied to group practices with 10+ EPs

Spring 2014 — Sept. 30, 2014
PQRS group practice registration period

3rd Quarter
Retrieve 2014 QRURs
(all groups and solo practitioners)
Electronic Health Record (EHR) Incentive Program
EHR Incentive Program

• Authorized under the HITECH Act of 2009
• Medicare and Medicaid incentives available to hospitals and physicians for *meaningful use* of certified EHR technology (CEHRT) to improve patient care
• As of December 2013, over 80% of all EPs have register to participate in the EHR Incentive Program and about 64% of EPs (or 334,650 professionals) have received an incentive payment for meaningful use.
• Since 2011, CMS has paid more than $17.7 billion in incentive payments to physicians and hospitals
Medicare EPs Paid an EHR Incentive by Specialty: 2011-2013

General practice physicians 1.5 times more likely than specialty physicians to receive an incentive payment for 2012
Phased Approach to Meaningful Use

Meaningful use demonstrated by meeting specific objectives and reporting on specific clinical quality measures.

- **Stage 1**: Data capturing and sharing
- **Stage 2**: Advanced clinical processes
- **Stage 3**: Improved outcomes
Understanding EHR Incentives/Penalties

• Medicare EHR incentives available since 2011 and through 2016

• 2014 is the last year physicians can initiate participation to qualify for a Medicare EHR incentive
  ✦ New participants can earn up to $24,000 if they demonstrate MU from 2014 through 2016 (or $63,750 over 6 years under the Medicaid incentive)

• Beginning in 2015, physicians who do not successfully demonstrate meaningful use will be subject to a penalty.
  – 2015: -1.0%
  – 2016: -2.0%
  – 2017: -3.0%
  – 2018: -4.0%
  – 2019: -5.0%
  – 2020+: -5.0%
## Reporting Periods to Avoid Penalty

<table>
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<tr>
<th>First Year Demonstrating Meaningful Use</th>
<th>Requirement to Avoid Penalty in 2015</th>
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<tbody>
<tr>
<td>2011</td>
<td>Demonstrate meaningful use for a full year in 2013</td>
</tr>
<tr>
<td>2012</td>
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<tr>
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</tr>
<tr>
<td><strong>2014</strong></td>
<td><strong>Demonstrate meaningful use for a 90-day reporting period in 2014</strong> (must occur in the first 9 months of the CY 2014; EPs must attest to meaningful use no later than Oct. 1, 2014)</td>
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</table>
Hardship Exemptions

• Infrastructure — in area with insufficient internet access or other infrastructure barriers (e.g., lack of broadband)
• New EPs — newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to the payment adjustment
• Unforeseen circumstances — natural disaster or other unforeseeable barrier
• Patient interaction — 1) lack of face-to-face or telemedicine interaction with patients; 2) lack of follow-up need with patients
• Practice at multiple locations — lack of control over availability of CEHRT for >50% of patient encounters
How to Get Started:
EHR Incentive Program Checklist

1) Verify your eligibility (hospital-based MDs not eligible)
2) Register for the program (you can register before having CEHRT installed) at: https://ehrincentives.cms.gov/
3) Adopt CEHRT (see complete list of CEHRT at: http://healthit.hhs.gov/CHPL)
4) Demonstrate MU: meet the requirements and report data for a consecutive 90-day period during the first year of participation (and for a full year in each subsequent year)
5) Attest to demonstrating MU: Legal statement through Medicare's secure website that you've demonstrated MU with CEHRT
EHR Incentive Program: Important Dates

• Feb. 28, 2014: Attestation deadline for EPs for the 2013 program year (to earn 2013 incentive/avoid 2015 penalty)

• Oct. 1, 2014: Deadline to adopt and demonstrate meaningful use of CEHRT to avoid 2015 penalty of 1%

• Dec. 31, 2014: End of 2014 reporting period for EPs qualifying for EHR incentives
Additional Resources

Visit the following websites for detailed measure specifications, reporting requirements, and tip sheets and other instructions on how to get started:

Physician Quality Reporting System

Physician Value-Based Payment Modifier
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

EHR Incentive Program
http://www.cms.gov/EHRIncentivePrograms
It’s Time to Get Prepared

Peter Margolis, MD, AGAF
Just a Passing Storm Or Is It Climate Change?
You Don’t Want to Be Left Out
Agenda

• Present experience meeting
  – PQRS
  – VBPM
  – Meaningful use

• General strategy towards preparation and successful implementation

• Preparing for the ACA
Rhode Island Experience

• Smallest state in the Union
  – Under 1 million population
  – Very small geographical area
  – Few dominate health-care delivery systems

• Federal grants to establish coordinate care and alternative payment models

• Maturing primary care-based ACO and PCMH

• Self-funded health-care exchange

• Understanding your market is imperative
University Gastroenterology

• 19 physician providers/5 NP’s
  – Largest GI group in the state
  – Spread out geographically
  – 4 ambulatory endoscopy centers
  – Fully integrated EHR, attested
  – Data collection: patient surveys, AGA Registry, local insurer profiling, group specific metrics

• Embracing episode of care units and bundle
  – Access to new payors
General Strategy

• Committee structure
  – Processing committee, health-care reform committee, IT and Compliance committees
  – Research, develop expertise on regulation and policies
  – Educate partnership
  – Allocate staff and financial resources
  – Drive partnership’s reaction
PQRS — UGI Response

• CMS Claims-Based — 2013
  – Medication reconciliation claims
  – Initially to avoid penalties - 2013

• CMS-approved Registry — 2014+
  – AGA Digestive Health Recognition Program
    • Satisfied PQRS requirement for reporting
    • Compatible with our EHR
    • Cost efficient
    • Data reporting capability

• Started collecting data in early 2012
  • AGA Registry and Group metrics
PQRS — UGI Response

• Individual CMS measures identified
  – Reporting on HCV and IBD
• AGA reports the data to CMS
• AGA Digestive Health Recognition Program provides UGI data reports
  – Individual doctor data
  – Group collective data
  – National trends

• Process Committee monitors progress
PQRS — Success

• Attestation through CMS
  – Proof we have met PQRS standards
• Avoided CMS penalty box
• Two years of data: 2012–2013
  – Used the AGA Registry reports to negotiate with private payors and self-insured
• Goals of ongoing process
  – Continuing to collect data
  – Maintain quality
Value-Based Payment Modifier

• Quality Resource and Use Reports (QRUR)
  – CMS physician profiling reports
  – Physician feedback program
  – Groups of 100+: 2014

• Data...is King...
  – Summer 2014 UGI – review our QRUR reports
  – Improving physician adherence to measures
  – Improving patient outcomes and experience
Meaningful Use — UGI response

• Similar-committee structure
  – IT, Billing and Compliance committees
  – Identify staff with strength and expertise
  – Physician oversight and leadership

• Initial goals
  – Confirm our EHR is CMS-certified product
  – Ensure good flow of practice/physicians
  – Never to breach HIPPA
  – Collect appropriate/useful Data
Meaningful Use — UGI response

• Stage one requirements
  – Review the CMS core and menu measures

• Choose required measures based on criteria
  – Physician practice patterns
  – State requirements
  – EHR compatibility
  – GI patient appropriateness
Meaningful Use — UGI response

• Modified intake forms
  – Capture meaningful use data
  – MA or RN input information
  – Strict adherence to HIPPA Laws

• Criteria collected by staff at time of visit

• Physicians review and revise all information with patient
Meaningful Use — Success

• Attestation — All physicians attested
  – Individual NPI numbers
• Stage I incentives received
• EHR generates reports
  – Review physician compliance monthly
  – All report and actions are held in EHR for CMS review
• Reports value in ACO, PCMH and insurer relationship
Meaningful Use — Next Steps

• Stage II
  – Restarting the process
  – Focusing on advance clinical process
  – New core measures added value

• Stage III and so on
  – Will be easier to implement...hopefully
“A pessimist sees difficulty in every opportunity,

An optimist see opportunity in every difficulty...”

Winston Churchill
Questions?

For more information, visit

www.gastro.org