Advocacy and Policy

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Advocacy

"If you're not at the table, you're on the menu"

- Rapidly changing healthcare environment – we are at a crossroads
- Institution, local, state, federal opportunities
- High legislative staff turnover, limited understanding of healthcare issues

Case Study

Calendar Year 2019
Medicare Physician Fee Schedule
Proposed Rule (Non-QPP)

September 2018

Documentation of E/M services requires choosing the appropriate code

Currently, documentation requirements differ for each level

Clinicians rely on the 1995 and 1997 E/M documentation guidelines

Billing for an E/M visit requires the selection of a CPT code that best reflects:

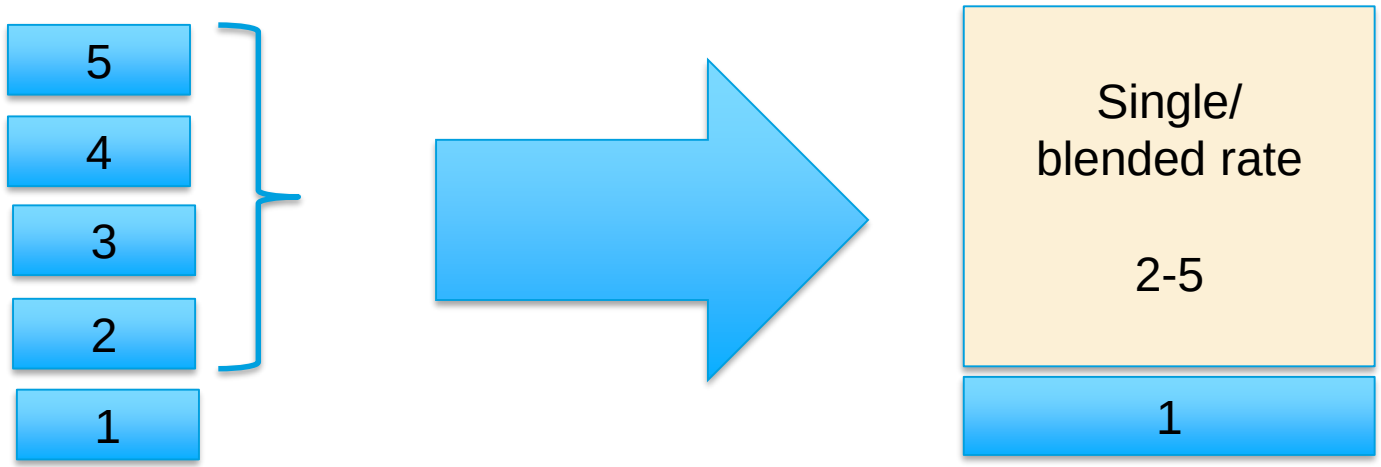
- Patient type (new vs. established);
- Setting of service (e.g., outpatient or inpatient); and
- Level of E/M service performed

83 Fed. Reg. at 35,839.

CMS proposes to establish a single/blended rate for levels 2 through 5 E/M office visits

There are currently 5 distinct code levels, with payment increasing for each level

CMS would establish a **single/blended payment** for levels 2 through 5 E/M office visits



This proposal <u>would not affect drug administration codes</u>

83 Fed. Reg. at 35,839.

CMS proposes to establish a single/blended rate for levels 2 through 5 E/M office visits, cont'd

There would be one blended rate for established patients and a separate blended rate for new patients

Payment Rates for Office/Outpatient E/M Visits: Current vs. Proposed					
Established Patients			New Patients		
Level	Current Payment	Proposed Payment	Level	Current Payment	Proposed Payment
1	$22	$24	1	$45	$44
2	$45	$93	2	$76	$135
3	$74		3	$110	
4	$109		4	$167	
5	$148		5	$211	

83 Fed. Reg. at 35,840 tbls. 19–20.

CMS proposes to reduce administrative burden of documentation requirements for E/M services

Option to document office/outpatient E/M visits using medical decision-making (MDM) **OR** time **OR** the current 1995 **OR** 1997 E/M documentation guidelines

Use time as the governing factor in selecting visit level and documenting E/M visits, regardless of whether counseling or care coordination dominate the visit

Use documentation standards currently required for level 2 E/M visits for levels 2 through 5 E/M visits

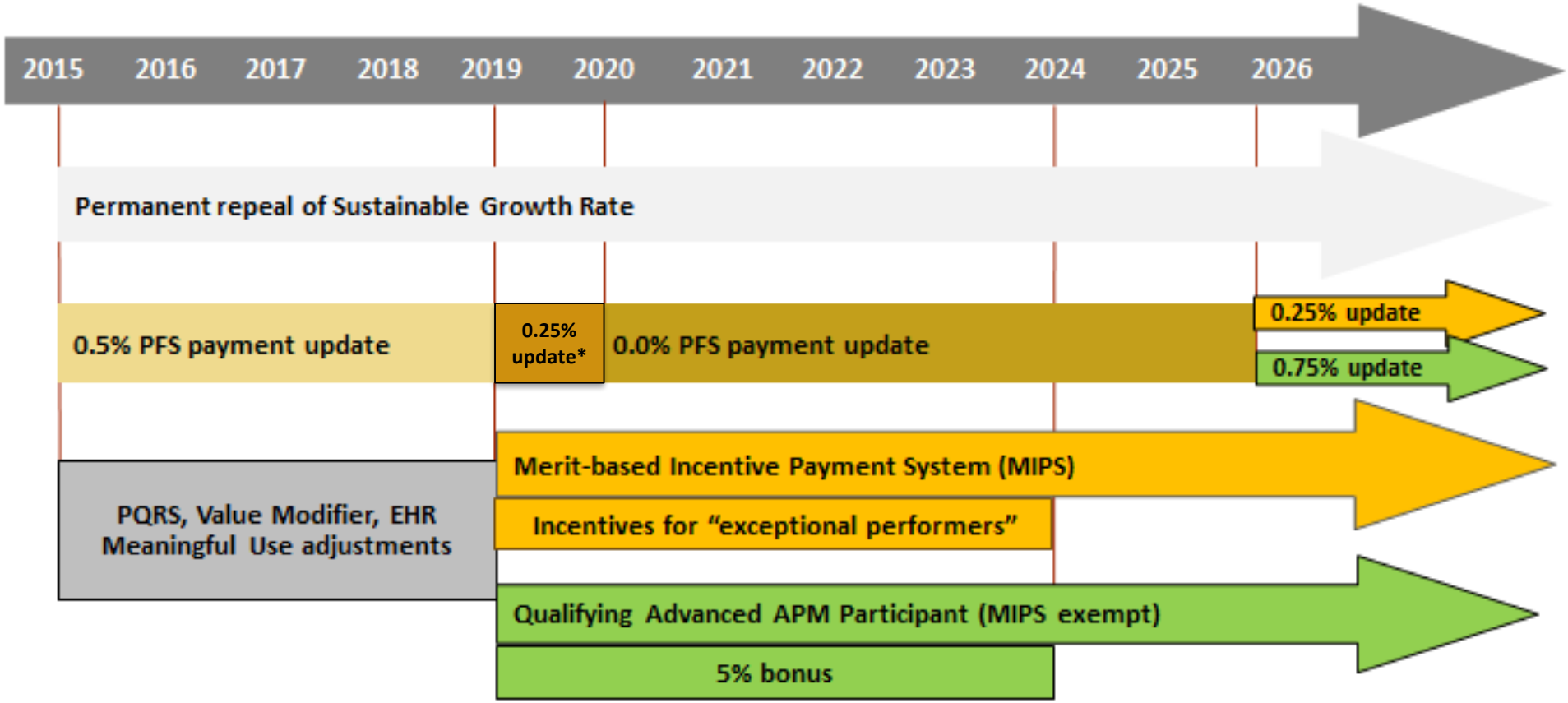
Document only what has changed from a prior visit or critical items that have not changed, rather than re-documenting information

83 Fed. Reg. at 35,836–38.

Quality Payment Program:
CY 2019 Proposed Rule

Merit-Based Incentive Payment System (MIPS)

Overview of the MACRA/QPP timeline – BBA impact



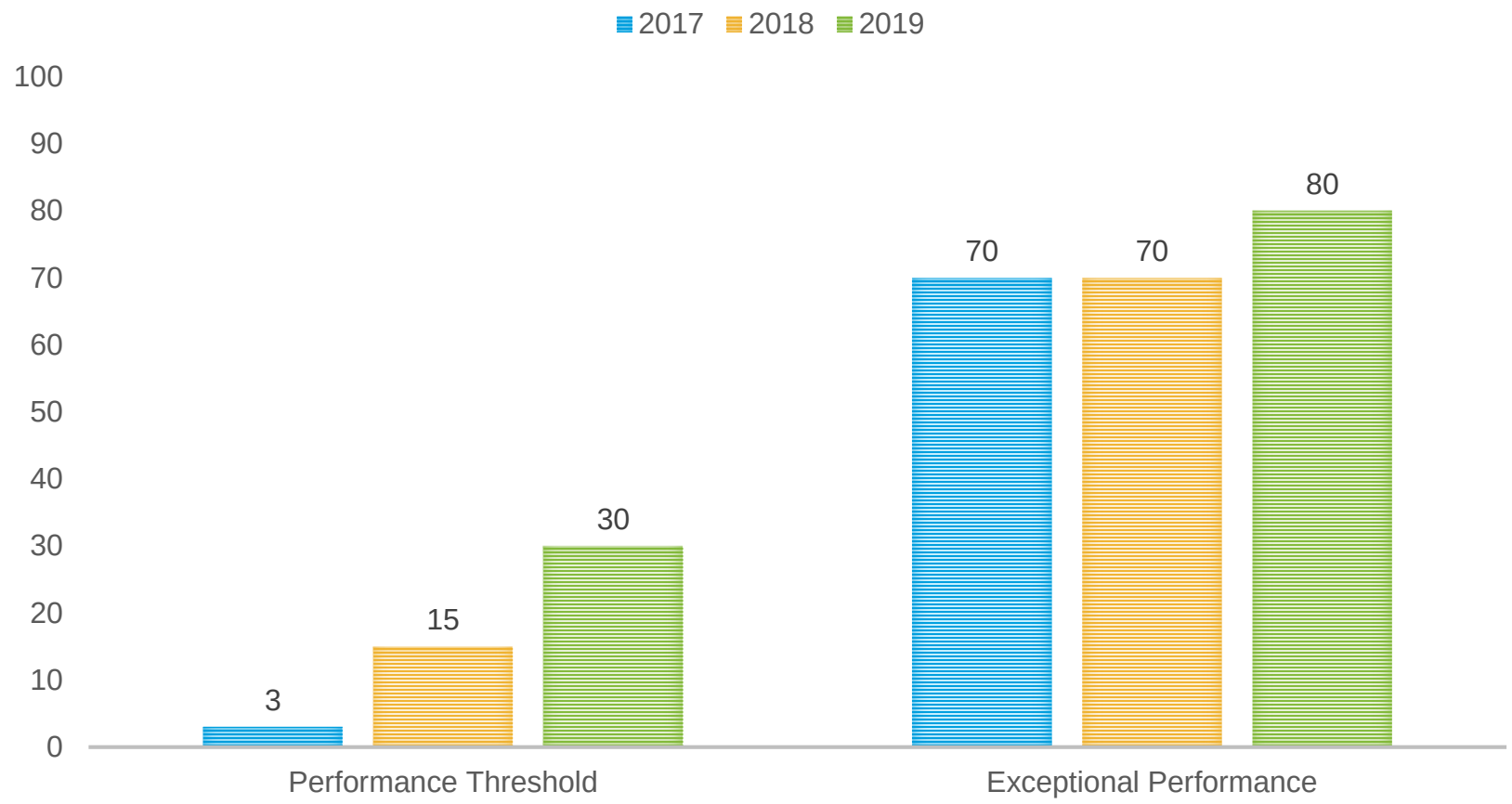
PFS = Medicare Physician Fee Schedule
PQRS = Physician Quality Reporting System
Value Modifier = Physician Value-Based Payment Modifier
EHR Meaningful Use = Medicare Electronic Health Record Incentive Program

BBA changes the PFS update to 0.25% for 2019

Summary of the Quality Payment Program (QPP)

- The **QPP** incentivizes the delivery of high-quality care through two tracks:
  - **Merit-based Incentive Payment System (MIPS)**; or
  - **Alternative Payment Models (APMs) incentives**
- On July 27, 2018, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule with comment period announcing policies for **Year 3** of the QPP, meaning:
  - CY 2019: performance period
  - CY 2021: payment year

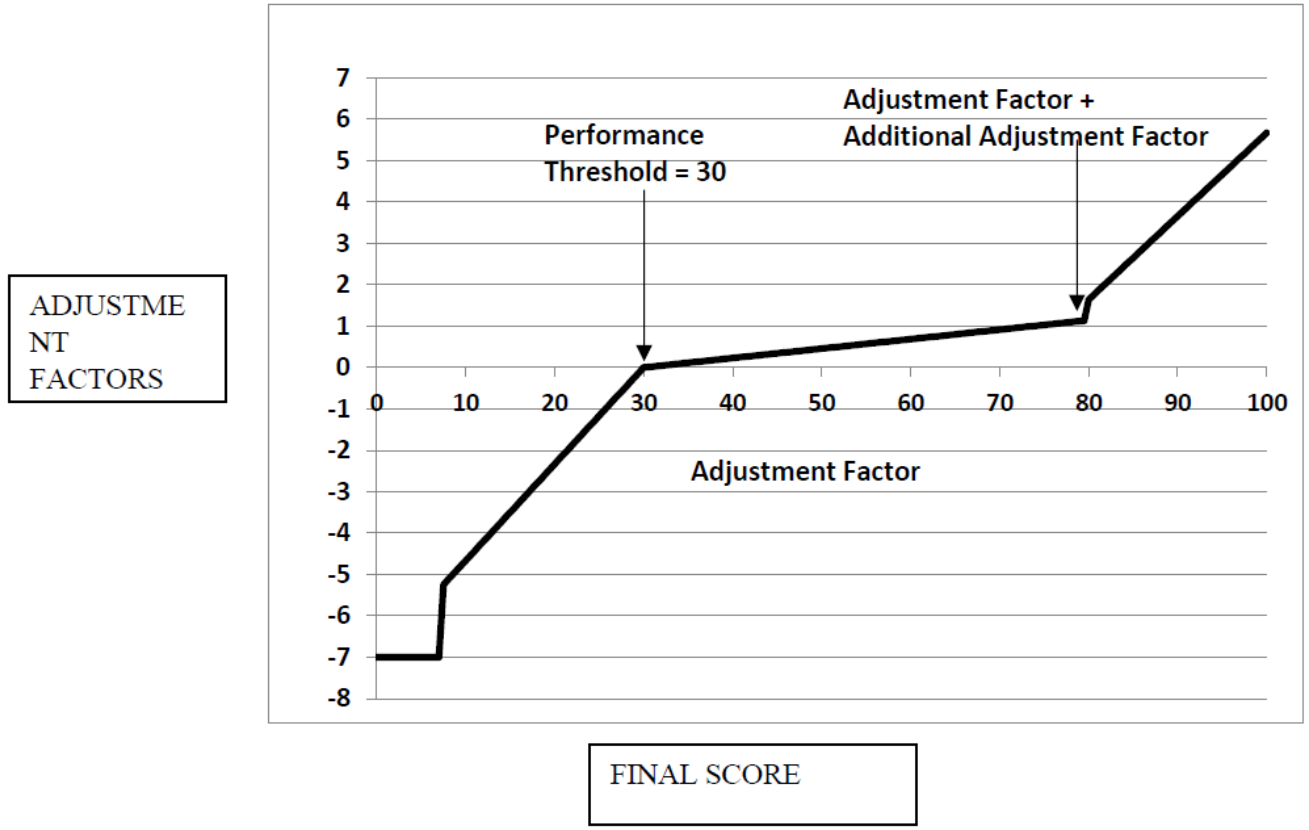
CMS proposes to increase the performance threshold needed to avoid a cut to 30 points and the threshold to earn a bonus to 80 points in 2019



83 Fed. Reg. at 35,972-73.

CMS predicts more than 9 in 10 MIPS eligible clinicians will earn a neutral or positive adjustment

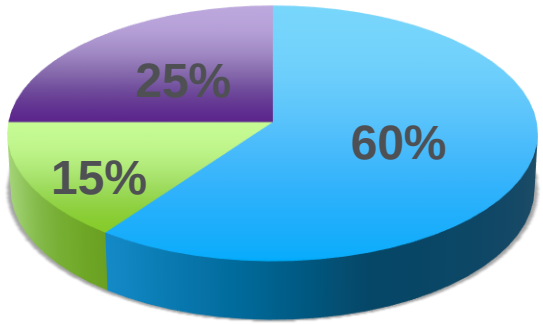
- In 2021 payment year, the MIPS payment adjustment is up to +/- 7%, but the vast majority of clinicians are expected to earn a modest positive payment adjustment (2% average)



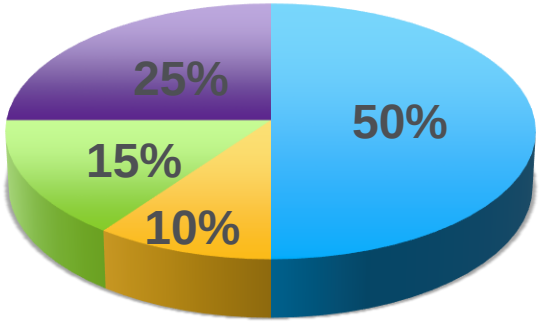
83 Fed. Reg. at 35,978, fig. A.

CMS proposes to increase weight of Cost, decrease Quality

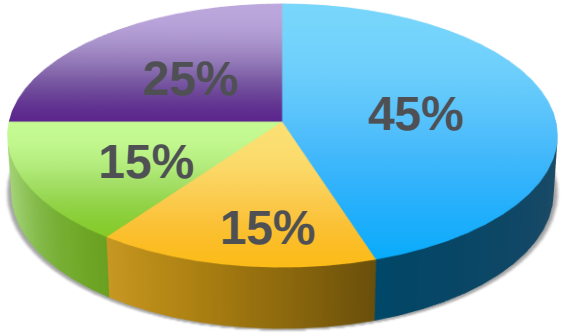
2017



2018



2019 (Proposed)



- Quality
- Promoting Interoperability
- Improvement Activities
- Cost

MACRA § 101(c)(5)(E)(i)(IV); 83 Fed. Reg. 35,896.

CMS proposes to introduce episode-based Cost measurement

Proposal: Introduce 8 new episode-based Cost measures (10 points each)

Type of Measure	Episode-Based Cost Measure	Attribution	Case Minimum
Procedural	Elective PCI	Each clinician that renders a triggering service	10
	Knee Replacement		
	Revascularization for Lower Extremity/Ischemia		
	Routine Cataract Removal		
	Screening Colonoscopy		
Acute inpatient	Intracranial Hemorrhage or Cerebral Infarction	Each clinician who bills an E/M service code during hospitalization if their TIN > 30% of the total E/M codes rendered during stay	20
	Pneumonia Hospitalization		
	STEMI with PCI		

83 Fed. Reg. at 35,903-05.

CMS proposes 5 required measures across 4 objectives under the renamed Promoting Interoperability category

Objectives (4)	Measures (5 required)	Maximum Points
E-Prescribing	e-Prescribing	10 points
	Bonus: Query of Prescription Drug Monitoring Program (PDMP)	5 points bonus
	Bonus: Verify Opioid Treatment Agreement	5 points bonus
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 Points
Public Health and Clinical Data Exchange	Choose two of the following: Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10 points

Proposal: Must report all required measures, and perform a Security Risk Analysis, to earn any points toward the Promoting Interoperability category score

83 Fed. Reg. at 35,917, tbl. 36.

Sign-On Letter

Adobe Acrobat Document

August 27, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Physician Fee Schedule for CY 2019 (CMS-1693-P)

Dear Administrator Verma:

The undersigned organizations representing physicians and other health professionals welcome and strongly support the Centers for Medicare & Medicaid Services' (CMS) "Patients Over Paperwork" initiative. We appreciate your outreach to our community and are solidly behind your goal of reducing administrative burdens for physicians and other health care professionals so that they can devote more time to patient care. The proposals included in the 2019 Medicare physician payment rule demonstrate that you listened to our members' concerns about the significant administrative burdens due to the documentation requirements associated with Evaluation and Management (E/M) services. We are grateful for your efforts to simplify these requirements and reduce their associated red tape.

Excessive E/M documentation requirements do not just take time away from patient care; they also make it more difficult to locate medical information in patients' records that is necessary to provide high quality care. Physicians and other health care professionals are extremely frustrated by "note bloat," with pages and pages of redundant information that makes it difficult to quickly find important information about the patient's present illness or most recent test results. Several of the documentation policy changes included in the proposed rule would go a long way toward alleviating this problem and the undersigned organizations urge immediate adoption:

1. Changing the required documentation of the patient's history to focus only on the interval history since the previous visit;
2. Eliminating the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient; and
3. Removing the need to justify providing a home visit instead of an office visit.

Implementation of these policies will streamline documentation requirements, reduce note bloat, improve workflow, and contribute to a better environment for health care professionals and their Medicare patients.

Regarding the proposal to collapse payment rates for eight office visit services for new and established patients down to two each, the undersigned organizations believe there are a number of unanswered questions and potential unintended consequences that would result from the coding policies in the proposed rule. We oppose the implementation of this proposal because it could hurt physicians and other health care professionals in specialties that treat the sickest patients, as well as those who provide comprehensive primary care, ultimately jeopardizing patients' access to care. We also urge that the new multiple service payment reduction policy in the proposed rule not be adopted as the issue of multiple services on the same day of service was factored into prior valuations of the affected codes. The proposal

Advocacy Do's and Don'ts

DO

- Identify yourself as a voting constituent in their district
- Use data or cases to tell your story
- Relate to situations in his/her home district
- Ask for specific action – cite the bill #
- Be professional
- Follow up with a thank you note

Don't

- Confront
- Threaten
- Pressure
- Beg
- Rant
- Use acronyms/jargon

Los Angeles City Council – Public Testimony

Video Link

Stay Informed

“Know Your State” tool

Newsletters

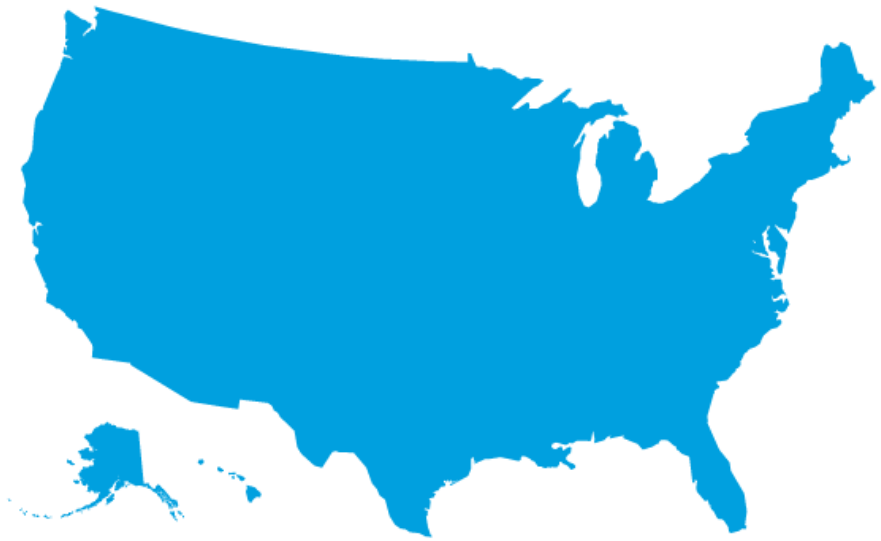
- Kaiserhealthnews.org – daily briefing
- MedScape – MedPulse
- Axios – Vitals
- Statnews – various

Twitter, Facebook

Know Your State
INTERACTIVE TOOL

CLICK NEXT TO CONTINUE

Help patients learn about medication access and affordability options one state at a time



CLICK THE MAP BUTTON TO VIEW STATE-SPECIFIC AFFORDABILITY OPTIONS

This interactive tool provides information on affordability options for patients. Topics covered include:

- Medicaid Expansion
- State Pharmaceutical Assistance Programs (SPAPs)
- Low-Income Subsidy (LIS) Eligibility Information
- State Health Insurance Assistance Programs (SHIPs)
- Standard Prior Authorization (PA) Forms
- National Foundations & Other Nonprofit Resources
- Oral Parity Laws
- Advocacy Connector
- Biosimilar Legislation
- Continuity of Care
- State Legislature Resources

Thank you

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