Nancey K. McCann

No Relevant Financial Relationships with Commercial Interests
Mid-Term Election Results

• 2014 Mid-term Election results mean changes for healthcare policy leadership.

• New Senate Finance Committee Chairman Orrin Hatch (R-UT); Former chairman Sen. Ron Wyden (D-OR) is now the Ranking Member

• Rep. Paul Ryan (R-WI) is the new Chairman of House Ways and Means Committee

• Rep. Fred Upton (R-MI) remains Chairman of Energy and Commerce Committee; Rep. Frank Pallone (D-NJ) is the new Ranking Member
What's the opposite of progress?
Working Together for a Change?
Priority Issues for Ophthalmology

- Passage of H.R. 2, the Medicare Access and CHIP reauthorization Act of 2015 (SGR repeal and 10 and 90 day global issue resolved)
- 21st Century Cures Initiative
- Repeal IPAB
- Private Contracting/Patient Shared Responsibility
- Drug Compounding
- Immediate Use Steam Sterilization
- Medicare Advantage Plans
- ASC Quality Reporting
- Accountable Care Organizations – exclusivity issue
- Quality Reporting Programs
Common Theme

*** All proposals (Bi-partisan) aimed at moving Medicare payment into a system based on outcomes, quality, and efficiencies

- In January 2015, HHS set a goal of tying 30 percent of fee-for-service Medicare payments to quality or value through alternative payment models, such as ACOs or bundled payments, by the end of 2016

- **Goal of tying 30% of traditional or fee-for-service Medicare payments to “quality or value” through alternative payment models (ACOs or bundled payment models) by the end of 2016; 50% of payments to these models by the end of 2018.**
Principles for SGR Reform

- Repeal the SGR
- 5-year period of payment stability and positive updates
- Choice of voluntary payment models – must maintain a viable fee-for-service option
- Positive incentives, rather than penalties, for quality improvement.
- Replace current PQRS/EHR/VBPM programs, if new quality-based payment system adopted – threshold verses peer vs peer.
- Quality measures determined by physicians
- Legal protections for physicians following guidelines and participating in quality programs.
SGR Repeal and Medicare Provider Payment Modernization Act
(H.R. 1470/S. 810)

- Merged with budget offsets and extensions of other programs
- Reintroduced as H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015
- Passed House of Representatives by a vote of 392 – 37 (March 26)
- Passed Senate by a vote of 92 to 8 (April 14)
- Signed into law by the President
- Repeals SGR immediately
- Conversion factor increases by 0.5% on July 1, 2015 – another 0.5% increase on January 1, 2016
- Includes 5 years of a 0.5% update to Medicare physician payments. (2015-2019)
- 2019 – 2025 fees maintained with additional payment adjustments through MIPS.
- 2026 and beyond – physicians in APMs would receive annual updates of .75%, while all others would receive annual updates of 0.25%,
- Consolidates the three existing quality programs (PQRS, EMR/meaningful Use/value-based Payment Modifier) – (eliminates penalties) into new Merit-Based Incentive Payment System (MIPS) that rewards providers who meet performance thresholds and penalizes those that do not.
SGR Repeal Legislation Continued

- Current penalties associated with existing programs are sunset after 2018.
- Physicians must still comply with current programs – subject to penalties until MIPS takes effect in 2019.
- Prevents CMS from moving forward with their policy to transition all 10 and 90 day global codes to 0 day codes.
- Provides 5% bonus to providers who receive significant portion of their revenue from an Advanced Payment Model (APM) – exempt from MIPS.
SGR Repeal Legislation Continued

- Use of quality performance measures as “standards of care” in medical malpractice claims brought in any court of law would be prohibited.
- EHRs would be required to be “interoperable” by 2017
H.R. 2 – Other Provisions

- Work GPCI floor extended through 2017
- Children’s Health Insurance Program (CHIP) extended through 2017
- Funds for Community Health Centers and the National Health Service Corps and the Teaching Health Center GME Payment Program extended through 2017
- Therapy caps exceptions process extended through 2017
- Qualifying Individual (QI) program – provides Part B premium support for low-income Medicare beneficiaries extended permanently.
- Transitional Medical Assistance (TMA) program – allows Medicaid recipients to maintain coverage for a year as they transition from welfare to work.
H.R. 2 – Other Provisions

• Medigap plan coverage limited to costs above the amount of the Part B deductible – for new enrollees beginning in 2020.

• Income-related premiums for Medicare Part B and D under current law readjusted
  – Incomes between $133,501 and $160,000 increase from 50% to 65%
  – Incomes at $160,001 and above increase from 65% to 80%
Transition of 10 and 90-Day Global Packages – included in 2015 Final Rule – rescinded by H.R. 2

- CMS finalized policy to refine bundles by transitioning over several years all 10 and 90-day global codes to 0-day global codes.
- The post-operative visits would be eliminated from 10-day global codes in CY 2017 and from the current 90-day global codes in CY 2018.
- This proposal would affect more than 4,200 codes, and CMS has not yet developed a methodology for making the transition to 0-day codes, even though they must begin to do so no later than February 2016.
Transition of 10 and 90-Day Global Packages – included in 2015 Final Rule

• CMS indicated they would most likely create new postoperative visit codes, which would be reimbursed at a lesser amount that the current E/M or eye codes and it is highly likely they would limit the number of post-operative visits

• ASCRS worked with AMA and surgical coalition to stop implementation. (Report language included in Cromnibus bill and provision to stop implementation included in H.R. 2)
“Misvalued” Codes Provision (Included in ABLE Act)

• Annual target of 0.5% in savings from misvalued services from 2017 – 2020.
• If target is met – savings are redistributed to other services and excess savings carry forward
• Otherwise – across-the-board cuts apply – not budget neutral
• Sets screens to identify potentially misvalued codes
• Secretary given wide discretion to collect information (surveys) to set the work and practice expense RVUs.
• GAO study on RUC processes
Medicare Patient Empowerment Act
H.R. 1650 – Congressman Tom Price (R-GA) – March 26, 2015

→ Allows docs and patients to privately contract on case-by-case basis

→ No Medicare opt-out

→ Hospital - other fees still paid

www.MyMedicare-MyChoice.org
Repeal the Independent Payment Advisory Board (IPAB)

• What is the IPAB?
  – 15 member, government board
  – Sole purpose: cut Medicare
  – Limited Congressional oversight
  – No judicial review
  – Hospitals exempt from cuts until 2020
  – Cuts on top of SGR and other Medicare cuts

• Sen. John Cornyn (R-TX)/Rep. Phil Roe, MD reintroduced legislation to repeal IPAB (S. 141/H.R. 1190)

• Could be considered as part of bi-partisan efforts to amend ACA.
Drug Compounding Law

• S. 959, the Pharmaceutical Compounding Quality and Accountability Act – passed Senate HELP Committee
• ASCRS, AAO, AMA successfully lobbied for changes to the bill.
• Compromise legislation- H.R. 3204, the Drug Quality and Security Act, (totally different bill) passed House under unanimous consent and was signed into law (P.L. 1113-54)
• Concerns about how FDA would regulate repackaged drugs like Avastin
• FDA recently released draft guidance on repackaging of biologics that will allow traditional compounding pharmacies and outsourcing facilities to repackage Avastin for ophthalmic use.
• ASCRS and other ophthalmology stakeholder groups have concerns with the short Beyond Use Dates (BUDs) the draft guidance lays out.
  – There are concerns that the 5-day expiration date will severely limit the use of Avastin.
• ASCRS is working in a coalition with other ophthalmology groups to notify the FDA of the issues surrounding these short BUD timeframes and asking these to be extended in the final guidance document.
Medicare Advantage Plans

- Medicare Advantage Participant Bill of Rights (H.R. 4998/S.2552 bipartisan legislation in the last Congress) and supported by ASCRS to prevent providers from being removed from MA plans mid-year
  - Sponsored by Sens. Sherrod Brown (D-OH), Richard Blumenthal (D-CT), and Rand Paul, MD (R-KY) – Rosa DeLauro – (D-CT – House)
  - Also requires MA plans to finalize provider networks 60 days prior to enrollment period and provides increased notice and information to plan enrollees
- ASCRS/ASOA responded to member complaints about physicians being dropped from MA plans “without cause”
- Brought issue to the attention of AMA and CMS.
  - CMS has already notified MA plans they must give CMS 90 days notice of planned network terminations and demonstrate ongoing network adequacy.
  - CMS released 2016 Medicare Advantage Plan call letter, which addresses some network adequacy issues, however, ASCRS still has some MA network adequacy concerns
21st Century Cures Initiative

- Bipartisan effort by the House Energy and Commerce Committee to speed access to new drugs and devices.
- Year-long study of current state of medical innovation. Testimony from FDA, NIH, industry, patient advocacy groups.
- ASCRS worked with the committee and has provided input
- Discussion Draft released on January 27. Includes:
  - Increasing flexibility in clinical trials,
  - Better integration of patient perspectives,
  - Improving data access and sharing,
  - Accelerated approval process for breakthrough devices,
  - Improved process for securing Medicare coverage for new drugs,
  - Increased funding for medical research,
  - Incentives for the development of new drugs and devices for unmet needs,
  - Provision to rescind the elimination of the 10 and 90 day globals, and
  - CME Exemption from Sunshine Act.
PQRS, EHR, Value-Based Payment Modifier - Quality Programs

• Medicare’s Quality Programs for MDs
  – Physician Quality Reporting System (PQRS)
  – Electronic Prescribing (eRx) – ended
  – Electronic Health Records (EHR)
  – Value-Based Payment Modifier (VBPM)

• Penalties for Non-Compliance only; No more incentive payments

• Penalties for these programs sunset in 2018, new Merit-Based Incentive Program (MIPS) payments begin in 2019
# Quality Reporting Program Penalties

<table>
<thead>
<tr>
<th>Quality Reporting Program</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<tbody>
<tr>
<td>eRx</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>PQRS</td>
<td>1.5%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>3 or 4% (depending on how many eligible professionals are participating in the Meaningful Use program)</td>
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<tr>
<td>VBPM</td>
<td>1% Applies only to practices of 100 or more</td>
<td>2% Applies only to practices of 10 or more</td>
<td>2-4% Depending on practice size</td>
<td>Will be decided in future rule making</td>
</tr>
<tr>
<td>Sequestration</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td>Total</td>
<td>6.5%</td>
<td>8%</td>
<td>9-11%</td>
<td>12% or greater</td>
</tr>
</tbody>
</table>
PQRS 2015

• **PQRS:**
  – Eligible professionals must report **nine PQRS** measures – and must cover at least three of the National Quality Strategy domains for 50% of the Medicare Part B fee-for-service patients they see during the reporting period to avoid a 2% PQRS Penalty.

  – There is no longer a PQRS incentive payment
PQRS 2015 Continued

• Of the measures reported, if an EP sees at least 1 Medicare patient in a face-to-face encounter, the EP must report on at least 1 broadly applicable measure contained in the cross-cutting measure set as 1 of their 9 measures.
PQRS 2015 Continued

• If less than 9 measures apply to the provider, they can report as many measures as apply (1-8) for 50% of the Medicare Part B fee-for-service patients seen during the applicable reporting period.

• If a provider reports less than 9 measures, they will be subject to the Measure Applicability Validation (MAV) process – which will evaluate whether there are additional measures that apply that they did not report.
PQRS 2015 Continued
For Ophthalmology

To successfully report for 2015 PQRS providers have a choice of reporting EITHER

1. The Cataract Measures Group via registry OR
2. 9 individual measures from the relevant ophthalmology and general care measures in 3 NQS domains.

If you are reporting the Cataract Measures Group, you must report 8 measures (increased from 4 measures in 2014) via registry for 20 patients, 50% (or 11) of which must be Medicare Part B patients.
If providers have less than 9 PQRS measures that apply to them, they should report general measures, such as:

**Measure 130:** Documentation of Current Medications in the Medicare Record or

**Measure 226:** Preventative Care Screening: Tobacco Use: Screening and Cessation Intervention
PQRS Qualified Clinical Data Registries

• New clinical data registry option permitting physicians to report quality measures used by the clinical data registry instead of the PQRS measure list.

• Registry must capture at least nine measures covering at least three of the National Quality Strategy domains.

• A list of Qualified Registry Vendors that have been approved by CMS is available on CMS’ ‘Registry Reporting’ webpage
Valued-Based Payment Modifier (VBPM)

- The Value-Based Payment Modifier program provides incentives and levies penalties based on the quality of care and cost of care that groups of eligible professionals provide under the Medicare Physician Fee Schedule.
- Adjustment is based on participation in the Physician Quality Reporting System (PQRS).
- The VBPM will apply to all physicians in CY 2017 based on 2015 PQRS reporting.
- Group practices or solo practitioners who do not successfully report for PQRS in 2015 will receive an additional VBPM (penalty) of 2-4% depending on group size.
• Successful PQRS participants (including group practices where more than 50% of the group successfully participated in PQRS) will be subject to a second “quality tiering” step where groups are compared nationally on quality and cost measures and have the potential to earn a bonus or penalty.

• In 2015, groups of 10 or more are no longer able to opt out of quality tiering.
VBM 2015 Changes

• 10 or More Eligible Professionals
  – 4% penalty for all groups of 10 or more eligible professionals that do not successfully report for PQRS in 2017
  – Quality Tiering
    • Maximum upward or downward adjustment +/- 4 times adjustment factor in 2017
    • -2 times adjustment factor for low quality/average cost or average quality/high cost
    • +2 times adjustment factor for average quality/low cost or high quality/average cost
    • Adjustment factor determined at the end of CY2015 based on the aggregate amount of downward payment adjustments
VBM 2015 Changes

• Groups of 2-9 EPs and Solo Practitioners
  – 2% penalty for all groups of 2-9 or solo practitioners that do not successfully report for PQRS in 2017
  – Quality Tiering
    • The maximum upward adjustment for groups of 2 or more EPs or solo practitioners is +2 times the adjustment factor.
    • They will not be subject to negative adjustments under quality tiering in 2017.
VBM 2015 Changes

- CMS will apply the VBM to groups of 2 or more non-physician eligible professionals in 2017 and to non-physician solo practitioners in 2018.
Physician Feedback Reports

- All eligible professionals have access to a confidential feedback report based on 2013 data for Medicare patients – Quality and Resource Use Reports (QRURs)
- Reports compare quality and resource use and provide a “preview” of how affected groups might fare under the VBM
Physician Compare

• Group level measures will be expanded to make all 2015 PQRS GPRO web interface, registry and EHR measures for practices of 2 or more EPs and ACOs available for public reporting in 2016.

• All 2015 PQRS individual measures collected via registry, EHR, or claims will be made available for public reporting in late 2016, if technically feasible.
Meaningful Use

- Eligible Professionals must attest to Meaningful Use for a full calendar year in 2015 - regardless of their Stage of Meaningful Use.
Stage 1 Meaningful Use

- 2014 was the final year to begin EHR Meaningful Use and qualify for incentive payments.
- CMS changed the reporting requirements for Meaningful Use Stage 1. Beginning in 2014, all eligible professionals, regardless of their stage of meaningful use, had to report on CQMs in the same way.
- Ophthalmologists must report for 2015:
  - All 13 of the Core Set Objectives and Measures
  - 5 out of 9 of the Menu Set Objectives and Measures (including 1 public health measure)
  - 9 Clinical Quality Measures (CQM) that are relevant to your practice from a list of 64.
    - Selected CQMs must cover at least 3 of the National Quality Strategy domains.
Stage 2 Meaningful Use

• Same number of EHR objectives
  – 17 core objectives
  – 3 of 6 menu objectives
  – Retains the scope of practice exclusion: all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice. Can report on blood pressure and exclude height and weight.
Stage 2 Meaningful Use

There are two Meaningful Use measures that require patients to take action.

- **Patient Electronic Access**: Provide patients with an electronic copy of their health information (including diagnostic test results, problem lists, medication lists, allergies).
  - This measure requires that 50% of patients have access to their information and that **5% of patients have used the capability to access and download their information**.
  - Suggestions are to have patients log in while in the office. Some EHR’s require email address collection for this measure but that is a requirement of a specific EHR vendor, not CMS.

- **Secure Electronic Messaging**: Use secure electronic messaging to communicate with patients on relevant health information.
  - Patients are offered secure messaging online and **at least 5% (of unique patients or their authorized representatives) have sent secure messages online**.
  - A secure message is any electronic communication between a provider and patient that ensures only those parties can access the communication. Please note, this does not have to be an email, nor does it have to be through your patient portal.
  - Secure messaging can be used to promote care coordination between visits, handle routine health issues, address patient questions and concerns, monitor patient condition(s), and help patients better manage their conditions. Secure messaging can be used for handling routine nonclinical tasks, such as medication refills and referrals.
Meaningful Use- Scribe Certification

- ASCRS and ASOA always took the position certified scribes could enter CPOE information based on FAQ, issued by CMS after Meaningful Use Stage 2 2012 Final Rule.
- Conflicting information was circulated that scribes were in fact not able to enter CPOE data for EHR Meaningful Use, however, ASCRS continued conversations with CMS.
- CMS requested a crosswalk between the duties, functions and educational areas of a medical assistant versus an ophthalmic scribe.
- As a result of this crosswalk, CMS stated that ophthalmic certified scribes will qualify to enter CPOE data under FAQ 9085.
Meaningful Use Proposed Flexibility Rule

- CMS released proposed flexibility rule that contains major changes to both Stage 1 and Stage 2 Meaningful Use.
- For 2015 only, CMS proposes to allow all EPs, regardless of their prior participation in Meaningful Use, to attest to an EHR reporting period of any calendar year quarter.
- For 2015 and 2016, new participants in EHR reporting program can attest for any continuous 90-day reporting period.
  - Returning participants in 2016 and 2017 would attest for a full year.
Meaningful Use Proposed Flexibility Rule

• Patient Engagement Measures
  – CMS proposes to change threshold from Stage 2 objective for Patient Electronic Access measure that requires patients to view, download or transmit their health information from 5% to equal or greater than 1 patient.
  – CMS proposes to change the Stage 2 Secure Electronic Access measure from being a percentage based measure to a yes-no measure stating ‘functionality fully enabled.’
Meaningful Use Proposed Flexibility Rule

• CMS is proposing to eliminate the distinction between menu and core measures and require all eligible professionals to report on 9 objectives and one consolidated public health reporting objective for both Stage 1 and Stage 2 of Meaningful Use.
Stage 3 Meaningful Use

- Stage 3 Meaningful Use Proposed Rule released on March 25, 2015
- Proposes following an optional Stage 3 year in 2017, all providers move to Stage 3 regardless of their prior Meaningful Use participation in 2018
- Lays out eight program objectives, with 16 associated measures, eligible professionals must meet to successfully attest to Stage 3 Meaningful Use such as:
  - Protect electronic protected health information (ePHI) - Generate and transmit permissible prescriptions electronically
  - Implement clinical decision support (CDS) interventions
  - Use CPOE for medication, laboratory, and diagnostic imaging orders
  - Provide access for patients to view online, download, and transmit health information, or retrieve health information
  - Provide summary of care record when transitioning or referring patient to another setting of care
- Maintains the reporting of CQMs in Stage 3
Merit-Based Incentive Payment System (MIPS)

- MIPS streamlines existing PQRS, VPBM and EHR Meaningful Use programs
  - Existing penalties sunset at the end of 2018
- MIPS will assess the performance of EPs based on 4 categories:
  - Quality: Current quality performance measures and new measures through rulemaking
    - EPs select which measures to report
  - Resource Use: Current VBPM program measures
  - Meaningful Use: Current MU requirements
  - Clinical Practice Improvement Activities
Merit-Based Incentive Payment System (MIPS)

• EPs will receive a composite performance score (0-100) based on their performance in the 4 categories.

• Composite score will be compared to a performance threshold.
  – Mean or median of all composite performance scores for all MIPS EPs during prior period
**Merit-Based Incentive Payment System (MIPS)**

- Positive, negative or neutral adjustment based on composite score.
- Negative adjustment: capped at 4% in 2019, 5% in 2020, 7% in 2021 and 9% in 2022.
  - EPs between 0 and ¼ of threshold get maximum negative penalty
  - EPs closer to threshold score get small negative payment adjustments
Merit-Based Incentive Payment System (MIPS)

• If Ep’s composite score is at the threshold - will not receive a MIPS payment adjustment
• Positive adjustment: higher performance scores receive proportionally larger incentive payments up to 3 times the annual cap for negative payment adjustments.
  – Additional incentive payment for exceptional performance (above 25\textsuperscript{th} percentile)
Merit-Based Incentive Payment System (MIPS)

• Encouraging Advanced Payment Model (APM) participation
  – EPs who receive significant share of revenues through an APM that involves risk of financial loss and quality measure component receive 5% bonus each year from 2019-2024.
  – Excluded from MIPS and most EHR Meaningful Use requirements

**Further details will be determined through rule-making**
Sunshine Act

• Requires manufacturers of drugs, devices, biologicals or medical supplies covered by Medicare, Medicaid or the Children’s Health Insurance Program to report to CMS any payments or transfers of value of more than $10 to physicians

• Open Payments data went live on September 30, 2014.

• Physicians can still register for Open Payments to review data before future data releases.

• Manufacturers and GPOs had a March 31, 2015 deadline for 2014 data submission. The data review period for physicians to review 2014 payments attributed to them began on April 6 and will last for 45 days before the data becomes public.
2015 ASC payment & quality reporting

• Conversion Factor $44.071
• Update still based on CPI-U with budget neutrality and productivity adjustment = 1.4%
• Previously, ASC-11: Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery was required for all ASCs
• 2015 ASC Final Rule: CMS changes ASC-11 from mandatory to voluntary for 2015
Accountable Care Organizations

- Previous Exclusivity Policy - Precluded any practice that performs E&M from full-fledged participation in more than one ACO – regardless of specialty.

- ASCRS, worked with the AMA, led an effort to address the exclusivity issue.

- Proposed regulation released on Dec 1 – revises exclusivity issue -CMS is proposing to exclude services provided by certain specialties from being limited to full participation in one ACO, including ophthalmology.
Going Forward

• Work for Passage in Senate of H.R. 2 – Signed into law by the President
• 21st Century Cures Initiative
• Advocate for private contracting and repeal of IPAB.
• Monitor Medicare Advantage Plans
• Immediate Use Steam Sterilization
• Continue to work with relevant stakeholders to ensure continued access to compounded drugs.
• Work to finalize ACO changes
What Can You Do?

- Growing Regulatory Burdens
- Threatened Access to Specialty Care
- Mounting Penalties

Get off the sidelines and...
What Can you Do?

• Join physicians/administrators to advocate for our priorities.
  • Visits, phone calls and emails made a difference in the development of the SGR repeal and replacement

• Your legislators need to hear from you!
  • Legislators care what people living and working in their districts think.
  • Illustrate the impact on patient care.
• Respond to Grassroots Alerts
• Meet with your Representative and Senators
  • Back home or in Washington D.C.
  • Alliance of Specialty Medicine Fly-In – July 13-15, 2015
• ascrsgrassroots.org.
ASCRS Fly-In

• Join other physicians/administrators in the Alliance of Specialty Medicine to advocate for our priorities.
• Learn about the political process-first hand.
• Meet directly with your elected officials.
Thank you!

Questions?

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