Final Rule Issued for MACRA Implementation

On October 14, 2016, the Centers for Medicare & Medicaid Services (CMS) released the final rule with comment period to implement MACRA’s Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). Collectively, these programs are part of what CMS now calls the Quality Payment Program (QPP). CMS has also issued a fact sheet, an executive summary, and an online toolkit on the payment program. It is evident from an initial review of the rule that CMS adopted numerous AMA recommendations and made significant improvements, including reducing reporting requirements for physicians to avoid penalties, creating a more realistic and flexible transition period, increasing the low-volume threshold that exempts more physicians, and eliminating the cost category in calculating the 2017 composite performance scores. Below is a partial summary of some of the key provisions. More information will be available in future issues. Watch for information on the Denver Medical Society 2017 Practice Management quarterly breakfasts which will focus on preparing your practice for successful MACRA compliance.

Quality Payment Program Overview
CMS finalized a transition year for the 2017 performance period, during which the only physicians who will experience a -4 percent payment penalty in 2019 are those who choose not to report any performance data. Physicians can avoid the payment penalty in 2019 by reporting for one patient on one quality measure, one improvement activity, or the 4 required Advancing Care Information (ACI) measures in 2017. Physicians who wish to possibly qualify for a positive payment adjustment must report more than the minimum one patient for one quality measure, improvement activity or the 4 required ACI measures.

Merit-Based Incentive Payment System (MIPS)
Overarching Issues

- **Shortens performance period:** Physicians who report for at least 90 continuous days in any of the three categories that will be included in the 2017 score will be eligible for positive payment adjustments.
  - The 2017 transition year with a 90-day reporting period is a significant reduction from the full calendar year reporting period that CMS required in the proposed rule.

- **Increases low-volume threshold:** CMS raised the low-volume threshold in the proposed rule to exempt physicians from all performance reporting to $30,000 in annual Medicare revenue or 100 or fewer Part B-enrolled Medicare beneficiaries. CMS estimates that this change will exempt 32.5 percent of eligible clinicians from the program.
  - The proposed rule called for a threshold of $10,000 in annual Medicare revenue and less than 100 Medicare patients.

- **Increases non-patient facing eligible clinicians encounter threshold:** CMS expanded the definition of a non-patient facing physician as an individual clinician that bills 100 or fewer patient-facing encounters during the non-patient facing determination period.
  - CMS had previously proposed to define a non-patient facing clinician as an individual clinician that bills 25 or fewer patient-facing encounters.
• **Provides for individual or group reporting:** The final rule retains a provision allowing data submission and performance assessment to be done at either the individual or group level. Physicians must choose to report as an individual or group consistently across all MIPS categories. CMS also plans to allow physicians to participate in virtual groups beginning in 2018.

Quality

• **Reduces reporting burden:** Physicians are required to report on 6 measures or a specialty measure set, one of which must be an outcome measure or, if no outcome measures are available, a high priority measure.
  o *This requirement is a decrease from the 9 quality measures physicians were previously required to report under the Physician Quality Reporting System (PQRS). CMS also eliminated the proposal to report on a cross-cutting measure as one of the six quality reporting measures.*

• **Reduces administrative claims measures:** An all-cause hospital readmissions measure was finalized for groups of 15 (up from 10 in the proposed rule) or more physicians and with 200 attributed cases. The measure will be calculated based off of administrative claims data.
  o *CMS eliminated its proposal to score physicians on the acute and chronic composite measures using administrative claims data.*

• **Reduces data completeness criteria:** In 2017, any physician who reports on one quality measure for at least one patient will receive at least 3 points on the measure, thereby avoiding a payment adjustment in 2019.

• **Reduces reporting thresholds:** In 2017, physicians have to report on a measure successfully on 50 percent of patients, and in 2018, physicians have to report on a measure successfully on 60 percent of patients. CMS intends to increase the measure thresholds over time. If a physician is only avoiding a penalty and not attempting to earn an incentive, they are only required to report on one patient in 2017.
  o *In the proposed rule, CMS required that physicians reporting via registry, Electronic Health Record (EHR), or Qualified Clinical Data Registry (QCDR) had to report on 90 percent of patients to report a measure successfully, and that physicians reporting via claims had to report on 80 percent of Medicare Part B patients to report a measure successfully.*

• **Increases quality percent of composite performance score:** 60 percent of the composite performance score will be based on the quality performance category in 2017, due to the reduction of the cost performance category weight to zero percent. 50 percent of the composite performance score will be based on the quality performance category in 2018. In 2019 and beyond, 30 percent of the composite performance score will be based on the quality performance category.
  o *In the proposed rule, the quality category was weighted as 50 percent of the composite performance score in 2017.*

• **Encourages the use of QCDRs and electronic sources:** CMS provides preferential scoring for physicians who report quality measures through an EHR, qualified registry, QCDR, or web-interface.

According to the AMA, this transition marks a monumental change in the practice of medicine which follows the repeal of the much maligned Sustainable Growth Rate (SGR). The AMA will be hosting two educational webinar sessions to help physicians prepare and understand what the final rule means for their practice. Both sessions will cover the same material and physicians as well as their staff are welcome to participate.

Register for November 21 at 5-6 PM Mountain Time [here](#)

Register for December 6 at 6-7 PM Mountain Time [here](#)
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Sepsis is a “medical emergency”, according to the Centers for Disease Control and Prevention (CDC). Many of us in healthcare have experienced the critical moments in diagnosing septic shock – the frenzied dash to draw blood cultures and lactate levels, to administer antibiotics, and to maintain the patient’s blood pressure with intravenous fluids without compromising the patient’s respiratory status. The unraveling of sepsis before our eyes is akin to witnessing ST-segment elevation in an acute myocardial infarction or facial droop in a stroke patient – the urgency to treat should be the same. The CDC statement strongly emphasizes the need for practitioners to refocus our priorities in combating this life-threatening condition.

Sepsis strikes over a million Americans each year, of which over 280,000 do not survive – far more than the number of US deaths from breast cancer, stroke, and automobile accidents combined. The financial burden to the health care system is extremely high as well. In 2013, sepsis accounted for over $24 billion in healthcare expenditures in the US. The average cost per hospital stay for a sepsis patient is over $18,000, almost double the average cost per stay across all other conditions. Severe sepsis could result in an increased length of stay from 6 to 17 days, equating to over $53,000 per episode.

Great strides have been made in the care of sepsis patients, beginning with the development of the Surviving Sepsis Campaign International Guidelines for Management of Severe Sepsis and Septic Shock (2012). These guidelines recommend best practices and organize them into two bundles of care to be completed within three and six hours of symptom presentation. Early studies showed an improvement in patient mortality by 50% or more through timely diagnosis, administration of IV antibiotics and fluids. However, compliance with the bundles remains low and reports highlight a wide discrepancy in mortality rates across the country. In Colorado, the mortality rate associated with sepsis may vary among hospitals from as low as 7% to as high as 30%.

The Coalition for Sepsis Survival (C4SS) is a Colorado-based nonprofit organization whose vision is to build and support a healthcare community where any sepsis patient has a 90% chance of survival, without residual disabilities. The C4SS mission is to significantly impact sepsis mortality and morbidity by leading state initiatives to build sepsis awareness and best practice treatment.

The objective of C4SS is to save 10,000 Coloradan lives and $200 million in lower healthcare costs over the next five years. C4SS supports three key initiatives: 1) Public Awareness, 2) Research and 3) Hospital and Healthcare Provider Performance Improvement Grants.

Public Awareness: It is hard to believe that the third leading cause of death in the US is not known by 50% of the US population. This may account for 80% of sepsis patients presenting to hospital emergency rooms, often at the end stage of their medical condition, where mortality increases by 8% for every hour a sepsis diagnosis is delayed. Last August, C4SS launched a twelve-month Public Service Announcement program that is airing on over 230 Colorado radio and television stations, educating the public to recognize the symptoms of sepsis.

Research: Across the US, sepsis hospital mortality rates vary from 10% to over 40%. C4SS is in discussion with over 40 Colorado hospitals proposing a statewide study to determine the factors behind this wide variance and to identify practical solutions that individual hospitals can implement, cost effectively, to reduce sepsis morbidity and mortality.

Healthcare Provider Grants: Regardless of a hospital’s financial condition, C4SS plans to offer education grants and low-cost financing to assist hospitals in implementing sepsis performance improvement programs. As part of this program, we are developing an “Endorsed Vendor” list. These are companies that C4SS will review and, as appropriate, endorse as recognized product and/or service providers that have demonstrated success in assisting hospitals and healthcare providers in reducing sepsis morbidity and mortality.

C4SS is actively seeking physicians, nurses, and healthcare institutions with a passion for reducing sepsis to participate in our Colorado Hospital Sepsis Survival Study. (continued on pg 6)
Money Talks: Discussing Cost with Patients Before Treatment is a Win-Win

“My knee still hurts after surgery, and I’m getting all these bills to pay that I didn’t know about.”

I thought it was going to be another typical day at my practice, but I found myself comforting an upset and frustrated patient who was still having a hard time returning to golf three months after having an arthroscopic medial meniscectomy. “What had I done wrong?” I asked myself.

“Mr. Jones” had made an appointment to see me after twisting his knee trying to kick a soccer ball around with his grandson. He was 62 years old and already had been treated by his primary care physician with medicine and therapy but had remained symptomatic with a torn medial meniscus on MRI. He was miserable because he had not been able to play golf and couldn’t even keep up with his wife on their evening walks. He was overweight, with a varus knee and early osteoarthritis on weight-bearing x-rays and MRI.

Of course, his internist and friends had told him that he needed an arthroscopic surgery and after that he would be all better.

Despite counseling him that he might still have knee pain after a meniscectomy due to the underlying arthritis, we agreed that an arthroscopic surgery was in his best interest to try to improve his lifestyle. We discussed all the medical and surgical risks and postoperative rehabilitation program. I connected him to my surgery scheduling team after carefully and clearly explaining his medical diagnosis and treatment.

I thought I had done a good job—but I was wrong. I had neglected to make sure he had been advised of all the growing financial obligations that our patients face today.

When the pain didn’t resolve completely after surgery—and Mr. Jones was receiving bills he hadn’t expected—I had an unhappy patient.

Miscommunication can Lead to Claims

Patient-physician miscommunication issues such as this one play a large role in contributing to malpractice claims. The Doctors Company has studied thousands of closed claims in various specialties and found that poor communication between the provider and the patient or the patient’s family is one of the key factors behind lawsuits. This issue contributes to 12 percent of cases for hospitalists and orthopedists and 14 percent of cases for obstetricians and emergency medicine providers.

A key component of good communication with patients is a discussion about financial obligations for the medical services provided. Good communication up front can help, especially if a surgical outcome or treatment does not lead to a perfect outcome.

Increasing numbers of physicians are joining large medical groups with a business manager or becoming hospital employees, which typically decreases their involvement with the business portion of healthcare. Most major medical insurance companies continue to sell policies with varying deductibles, co-payments, and complex rules. Unfortunately, these factors have led to an increasing disconnect between the patient and the physician when it comes to discussing financial obligations.

The physician needs to be involved in making sure that the patient is informed and educated about the financial burden of surgical and medical treatments. Doing this before proceeding with treatment can help lower the risk of a malpractice claim even when the medical outcome doesn’t meet the patient’s expectations. Understanding the financial commitment up front allows patients to make a more informed decision for care.

How to Ensure Financial Disclosure

In our office, we have established a series of steps for our patients once the patient has decided to proceed with elective surgery. These steps can be adjusted for non-surgical specialties:

- At the time of the office visit, the office staff provides the patient with a surgical information packet that includes a direct telephone number to the physician’s care coordinator (PCC). The staff tells the patient to contact the PCC once he or she has decided to proceed with surgery.
- The patient and the physicians also complete three forms with information that a staff member then enters into our electronic medical record:

(continued on page 6)
1. Surgery procedure form, completed by the physician with the appropriate CPT and ICD-10 codes.
2. Anesthesia medical questionnaire form, completed by the patient.
3. Durable medical equipment (DME) form, completed by the physician.

- If the patient then contacts the PCC to proceed with surgery:
  - The PCC contacts the insurance provider. If precertification is required, the office notes this and sends other data (MRIs, etc.) to the provider to authorize.
  - The PCC then confirms the provider authorization

Once the insurance provider has certified surgery, the PCC will contact the patient to schedule a surgery date and ensure that, if needed, the patient will obtain an appropriate medical clearance by the time of the preoperative office visit. The type of medical clearance required, if any, is determined by the criteria set by the anesthesia medical questionnaire form.

The PCC then sends the correct surgical date, CPT codes, and ICD-10 codes to:

- **Office financial advisor:** This advisor will discuss the patient’s insurance plan, deductible, and co-pay; establish the surgeon’s fee based on the expected procedure; and require a patient deposit at the time of the preoperative office visit. The deposit amount is designed to minimize the need for patient refunds due to overpayment post surgery.

- **Surgery center:** The surgery date will be set and the surgery center financial advisor will contact the patient and discuss the patient’s insurance plan, deductible, and co-pay; establish the facility and anesthesia fees based on the expected procedure and require another patient deposit prior to the date of surgery.

- **DME company:** A private DME company will contact the patient and discuss payment costs and options for the DME requested by the physician.

By paying attention to both the medical and financial details, we are more likely to have happier patients, physicians, and surgery centers. Realistic medical and financial expectations discussed prior to elective surgery or other medical treatment can result in better efficiency, better outcomes, and less litigation.

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**Contributed By Ralph A. Gambarella, MD, Chairman and President of Kerlan-Jobe Orthopaedic Clinic, and a member of The Doctors Company’s Orthopedic Advisory Board.**

### Sepsis Survival

*(continued from pg 4)*

Study will include:
1) Emergency Room Data, 2) In-Hospital Data, 3) Staff Knowledge Assessment, and 4) Staff Cultural Assessment. The first phase will focus on an analysis of patient medical records to determine the accuracy of sepsis mortality rates, assess the variability in coding practices, evaluate sepsis readmission rates, and quantify the financial impact of sepsis, including length of stay, direct cost, contribution margin and reimbursement. If you and members of your organization are interested in participating in this study, please contact Myrna Schnur: mschnur@c4ss.us or by phone at 303-929-1125.

If you would like to get involved as an Advisory Board Member to C4SS, please contact Suellyn Younkes, Executive Director at syounkes@c4ss.us.

To learn more about the Coalition for Sepsis Survival, please visit our [website](#).

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**Contributed by Myrna Schnur, RN, MSN**

**Clinical Affairs, Coalition for Sepsis Survival (C4SS).**

**References:**

To: Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Providers

On October 11th the Department made the decision to postpone the Go Live date of:
- Our new claims payment system (the Colorado interChange),
- The new provider web portal, and
- The new Pharmacy Benefits Management System.

The new Go Live date is March 1, 2017.

Providers should continue to use their current processes for submitting claims, prior authorization requests and provider enrollment updates to the Department. Claims will continue to be processed and paid as they are currently.

The additional four months will allow providers and partners more time to complete the enrollment and revalidation process, receive comprehensive training and prepare for associated changes in their business processes. The Department will conduct additional systems testing during this time.

The Department will post updates and resources including revised deadlines on our Provider Resources web page.

We appreciate your continued commitment to serving our more than 1.3 million Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+) members.
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