Centers for Medicare and Medicaid
CMS 2016 - 2017 Updates

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## Agenda

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Bundled Payments for Care Improvement (BPCI) Initiative Model 4 - Update

Acute Care Hospital Stay Only

- BPCI is a Center for Medicare & Medicaid Innovation (CMMI) is a bundled payment initiative intended to align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners.

- Models 2 – 4 incorporate a 3-year period of performance. Those that began on 10/1/2013 would end their participation on 9/30/2016.

- In Model 4 CMS makes a single prospectively determined bundled payment to the hospital that includes all services furnished during the inpatient stay by the hospital, physicians, and other practitioners.

Note: The BPCI initiatives will be extended until September 30, 2018
Bundled Payments for Care Improvement (BPCI) Initiative Model 4 - Update

- Physicians and other practitioners submit “no-pay” claims to Medicare Part B. These providers will be paid by the hospital out of the global bundled payment.

- The payment arrangements include financial and performance corresponding to the episodes of care.

- Related readmissions for 30 days after hospital discharge are included in the bundled payment amount.

- Hospital providers taking part in the program can choose from 48 episodes of care. (Ex: Knee replacement)

- There are 9 participating sites at this time
Sequestration

Mandatory Payment Reduction of 2% Continues until Further Notice for the Medicare FFS Program – “Sequestration”

Medicare Fee-For-Service (FFS) claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will continue to incur a 2 percent reduction in Medicare payment until further notice. Claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), including claims under the DMEPOS Competitive Bidding Program, will continue to be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013. The claims payment adjustment will continue to be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.
Sequestration

Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare’s payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. CMS encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to continue discussions with beneficiaries on the impact of sequestration on Medicare’s reimbursement.
Comprehensive Primary Care Plus (CPC+) Initiative

• On April 11, 2016, the CMS announced its largest-ever initiative to transform and improve how primary care is delivered and paid for in America. The effort, the Comprehensive Primary Care Plus (CPC+) model, will be implemented in up to 20 regions and can accommodate up to 5,000 practices, which would encompass more than 20,000 doctors and clinicians and the 25 million people they serve. The initiative is designed to provide doctors the freedom to care for their patients the way they think will deliver the best outcomes and to pay them for achieving results and improving care.
CPC+ Initiative (cont.)

• Building on the Comprehensive Primary Care initiative launched in late 2012, the five-year CPC+ model will benefit patients by helping primary care practices:

• Support patients with serious or chronic diseases to achieve their health goals

• Give patients 24-hour access to care and health information

• Deliver preventive care

• Engage patients and their families in their own care

• Work together with hospitals and other clinicians, including specialists, to provide better coordinated care
Primary care practices will participate in one of two tracks. Both tracks will require practices to perform the functions and meet the criteria listed above.

Practices in Track 2 will also provide more comprehensive services for patients with complex medical and behavioral health needs, including, as appropriate, a systematic assessment of their psychosocial needs and an inventory of resources and supports to meet those needs.
CPC+ Initiative

• CPC+ will help practices move away from one-size-fits-all, fee-for-service health care to a new system that will give doctors the freedom to deliver the care that best meets the needs of their patients. In Track 1, CMS will pay practices a monthly care management fee in addition to the fee-for-service payments under the Medicare Physician Fee Schedule for activities.

• In Track 2 (begins January 2017), practices will also receive a monthly care management fee and, instead of full Medicare fee-for-service payments for Evaluation and Management (E&M) services, will receive a hybrid of reduced Medicare fee-for-service payments and up-front comprehensive primary care payments for those services. This hybrid payment design will allow greater flexibility in how practices deliver care outside of the traditional face-to-face encounter.
CPC+ Initiative and Crossover Claims

• CPC+ Medicare crossover claims that will begin flowing in January 2017 may be identified by demonstration project code 78 and use of Claim Adjustment Reason Code (CARC) 132.

• No changes to COBA trading partners in terms of coinsurance amounts owed on these 837 professional claims; the coinsurance is still determined based upon Medicare’s approved amount prior to the CARC 132 reduction for CPC+. 
What is MACRA?

The Medicare Access & CHIPs Reauthorization Act is a bipartisan legislation that was signed into law April 16, 2015.

How does the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) reform Medicare payment?

The MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries. These changes include:

• Ending the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers’ services.

• Making a new framework for rewarding health care providers for giving better care not more just more care.

• Combining our existing quality reporting programs into one new system.
How do the MACRA payment reforms work?

• The MACRA will help to move toward the goal of paying for value and better care. It also makes it easier for more health care providers to successfully take part in quality programs in one of two streamlined ways:

• Merit-Based Incentive Payment System (MIPS)

• Alternative Payment Models (APMs)

• MIPS and APMs will go into effect over a timeline from 2015 through 2021 and beyond.
CMS Social Security Number Removal Initiative (SSNRI)

• Since the beginning of the Medicare program, the SSN based Health Insurance Claim Number (HICN) has been used as the beneficiary identifier for administering the Medicare program.

• CMS uses the HICN with multiple parties, such as Social Security Administration (SSA), Railroad Retirement Board (RRB), States, Medicare providers, Medicare plans, etc.

• Given the risk of identity theft, Congress passed and the President signed into law, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, mandating the removal of the SSN-based HICN from Medicare Cards.
CMS Social Security Number Removal Initiative (SSNRI)

• CMS will solicit input from stakeholders at various points throughout the project to ensure a smooth transition that maintains beneficiaries’ access to care while avoiding disruptions to the payment process.

• CMS will also conduct extensive outreach and education for beneficiaries, providers, private insurers, clearinghouses, Medicare contractors, state Medicaid agencies, and other stakeholders before new cards are mailed to beneficiaries.

• Per the law, Medicare cards will be issued with a new MBI to approximately 60 million beneficiaries by April 2019.
CMS Social Security Number Removal Initiative (SSNRI)

Timelines

• CMS will be generating new Medicare billing identifiers (MBI) for all Medicare beneficiaries, both living and deceased (archived). New Medicare cards will start being distributed by April 2018

• All systems and business processes will need to be able to accept and process transactions using the new MBI by April 2018

• Estimated that over 60 million Medicare cards with the MBI will be distributed to beneficiaries between April 2018 and April 2019

• The transition period is currently planned to begin in April 2018 and end on December 31, 2019
ICD-10 Updates

Update!
Update!
2017 ICD-10-CM and ICD-10-PCS Code Updates

- The 2017 ICD-10-CM and ICD-10-PCS code updates, including a complete list of code titles, are available on the 2017 ICD-10-CM and GEMs and 2017 ICD-10-PCS and GEMs webpages. The posted files contain the complete versions of both ICD-10-CM (diagnoses) and ICD-10-PCS (procedures).
ICD-10 CMS News Update August 12, 2016

Keep Up to Date on ICD-10

• Visit the CMS ICD-10 website for the latest news and official resources, including the Next Steps Toolkit, ICD-10 Quick Start Guide, and a contact list for provider Medicare and Medicaid questions.

• Sign up for CMS ICD-10 Email Updates
ICD-10 2017

ICD-10-PCS FY 2017 Version
FY 2017 Update Summary

<table>
<thead>
<tr>
<th></th>
<th>2016 Total</th>
<th>New codes</th>
<th>Revised Titles</th>
<th>Deleted Codes</th>
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<tr>
<td><strong>Total</strong></td>
<td>71,974</td>
<td>3,827</td>
<td>491</td>
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*CMS 2017-ICD-10-PCS-and-GEMs codes*
Medicare Crossover Updates

• New requirement for Medicaid MCOs to join the Medicare COBA crossover process—

• The recent publication a final regulation (2390-F in the Federal Register, dated May 6, 2016; see page 27555) contains the following language:
  – Section (r)—makes it clear that MCO, PIHP, and PAHP contracts that cover Medicare-Medicaid dually eligible enrollees and delegate the State’s responsibility for coordination of benefits to the managed care plan will be required to sign up for the national Medicare COBA crossover process in States that already use the automated crossover process for Fee-For-Service Claims
  – All State managed care plans will be required to sign up with the COBA crossover process in advance of July 1, 2017, as stated in the May 6, 2016 final regulation
    • Medicaid managed care plans within each State will obtain a COBA ID in the 77000 COBA ID range – ensures that commercial insurers that serve as Medicaid managed care plans will not be charged the per claim crossover fee.
Meaningful Use (MU) of Certified Electronic Health Records (EHR) Technology

Changes to Meaningful Use Requirements

• All providers are required to attest to a single set of objectives and measures, beginning in 2015.

• For all eligible professionals in 2015 through 2017 (Modified Stage 2), there are 10 objectives. For all eligible hospitals and CAHs, there are 9 objectives.

• Beginning on a voluntary basis in 2017 and required beginning in 2018, all providers will attest to Stage 3 objectives and measures. More information about reporting in 2017 and beyond will be available in 2016.

• Additional information related to EHR Incentive Programs’ requirements for 2015 through 2017 (Modified Stage 2) and Stage 3 can be found in the final rule.
What is Meaningful Use (MU) ?

Meaningful use is using certified electronic health record (EHR) technology to:

- Improve quality, safety, efficiency, and reduce health disparities.
- Engage patients and family.
- Improve care coordination, and population and public health.
- Maintain privacy and security of patient health information.
Meaningful Use Stages

**Stage 1** – requires that eligible providers meet a set of 14 core and 5 menu items to qualify to receive and EHR incentive payment for the calendar year. Provider must meet Stage 1 measures and objectives for 2 calendar year’s before progressing to Stage 2.

**Stage 2** – requires that eligible provider meet a set of 17 core and 3 menu items to qualify for EHR incentive payments for the calendar year. Stage 2 measures are more challenging than the Stage 1 measures. Providers must meet Stage 2 measures for 2 year’s before moving on to Stage 3.

**Stage 3** – is set to begin as an optional requirement for physicians and hospitals in 2017 and required in 2018. The new requirements for certification and subsequent participation in the program are significant and will be challenging for some EHR vendors to deliver in the aggressive timelines proposed.
Meaningful Use (MU) of Certified Electronic Health Records (EHR) Technology

Changes to Meaningful Use Requirements

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Meaningful Use (MU) of Certified Electronic Health Records (EHR) Technology

One of the more interesting changes in The EHR Incentive Program for 2015 through 2017 Final Rule was the removal of the 5% threshold for two objectives related to patient engagement.

- There are two objectives for Eligible Providers (EPs) that specifically contain measures requiring a provider to track patient action. CMS removed the 5% threshold requirement for these two measures that require patient action in order for the provider to meet the measure.
Meaningful Use (MU) of Certified Electronic Health Records (EHR) Technology

CMS finalized the measures for 2015(reporting 2016) as follows:

Objective 8: Patient Electronic Access Measure 2

• Removed the 5 percent threshold for Measure 2 from the EP Stage 2 Patient Electronic Access (VDT) objective. Instead for an EHR reporting period in 2015 and 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.

• For 2017: For an EHR reporting period in 2017, more than 5 percent of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.
Objective 9: Secure Electronic Messaging

- Converted the measure for the Stage 2 EP Secure Electronic Messaging objective from the 5 percent threshold to a yes/no attestation. For an EHR reporting period in 2015, the capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period. For an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.
Meaningful Use (MU) of Certified Electronic Health Records (EHR) Technology Stage 3

- EPs must attest YES to conducting the security risk analysis upon installation or update to the new Edition of certified EHR Technology.

- eRx- more than 80% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

- Clinical Decision Support-
  - Measure 1 – Implement five clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period.
  - Measure 2 – The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
Meaningful Use (MU) of Certified Electronic Health Records (EHR) Technology Stage 3

• Patient Electronic Access to Health Information
  – Measure 1 – More than 80% of all unique patients seen by the EP (i) The patient (or patient-authorized representative) is provided access to view online, download, and transmit their health information within 24 hours of its availability to the provider; OR (ii) The patient (or patient-authorized representative) is provided access to an ONC-certified API that can be used by third-party applications or devices to provide
  – Measure 2 – The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35% of unique patients seen by the EP during the EHR reporting period.

Complete Stage 3 requirements can be reviewed at link:

http://www.practicefusion.com/blog/meaningful-use-stage-3/
Meaningful Use (MU) of Certified Electronic Health Records (EHR) Technology

Summary:

• In 2015 over 4 in 5 of all non-federal acute care hospitals had adopted a Basic EHR with clinician notes, whereas, 80 percent of small hospitals with less than 100 beds, rural hospitals, and critical access hospitals had adopted a Basic EHR with clinician notes

ONC EHR Dashboards can be found at:

http://dashboard.healthit.gov
Questions