

ISSUE BRIEF

PERSPECTIVES FOR THE HEALTHCARE INDUSTRY

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Issue Brief: 8 Physician Pressure Points in 2016

As a physician it must seem that Medicare is changing the rules of the game every day. From new reporting requirements and updated clinical guidelines to adjusted benchmarks – physicians are right to think it’s a never-ending process. So here are 8 pressure points that matter most to all doctors this year, beginning with a calendar to keep them straight:

Key 2016 Dates for Physicians

Q1	First ICD-10 coding audits
	State public hearings & announcements on insurance mergers
January	Meaningful Use 2016 requirements effective
	New Two Midnight Rule effective
	Advance care planning reimbursement available
	Near flat 2016 Medicare conversion factor effective
	Expanded Medicare telehealth reimbursements effective
	Stark law easements and Medicare ACO waivers effective
	New Value Based Payment Modifier requirements effective
March	Meaningful Use 2015 attestation due
	MIPs Draft Regulation to be released
April	Comprehensive Care for Joint Replacement Model begins
June	Open Payments 2015 data published
	Decisions for all SCOTUS cases due
July	Meaningful Use 2016 attestation exemption due
Q3+	DOJ and FTC insurance merger announcements expected
October	2016 Meaningful Use attestation due for new physicians
	ICD-10 claims flexibility ends
November	Final APM rule expected
	CMS 2016 Value and APM Goals update expected
December	Final MIPS rule expected
	Medicare Physician Compare 2016 data published
Unspecified	Medicare discharge planning requirements released
	Meaningful Use Stage 3 changes expected
	Federal Teladoc and False Claims Act verdicts released

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Analysis is Navigant Healthcare’s research center that focuses on trends and issues relevant to each of the industry’s major sectors. The Center’s role is to monitor signals from the market, identify innovative solutions and facilitate implementation in this fastchanging environment.

I. MEDICARE REIMBURSEMENTS AND VALUE BASED PAYMENTS

Paramount for all physicians in 2016 is Medicare's redesign of the physician payment methodology. As part of the 2015 agreement to replace the Sustainable Growth Rate¹, this spring CMS will release a draft of the Merit-Based Incentive Payment System (MIPS), which will combine several value-based programs and will increase or decrease physician payments 9% by 2022. And CMS will clarify new payment policies for Alternative Payment Model participants detailing how to qualify for 5% incentive payments and to be excluded from MIPS. Both draft rules will be open for public comment with final versions expected by November 1st for APMs and December 31st for MIPS.²

At the same time CMS is moving full steam-ahead with existing pay-for-value initiatives including the Value-Based Payment Modifier Program, which adjusts payments up to 2% for physicians in TINs with 10 or more eligible professionals, a decrease from 100 EPs and up from 1% last year. And physicians should remember that their 2016 performance will impact their 2018 Value Modifier adjustment.³

In January, 121 new ACOs increased the total to 477 Medicare Accountable Care Organizations in 2016⁴ and soon following was the announcement that HHS - - nearly one year ahead of schedule - - reached its goal for 30% of all Medicare fee-for-service payments through alternative payment models.⁵ And April 1st means the start of HHS' first mandatory bundled payment program, the Comprehensive Care for Joint Replacement (CJR) model, for hospitals in 67 locations.⁶

Providers should expect CMS to do everything possible to meet its remaining 2016 and 2018 value-based goals - - including expanding CJR participation or introducing another mandatory bundle program.⁷

1. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>
2. <http://www.reginfo.gov/public/do/eAgendaViewRule?publd=201510&RIN=0938-AS69>
3. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/valuebasedpaymentmodifier.html>
4. <http://www.hhs.gov/about/news/2016/01/11/new-hospitals-and-health-care-providers-join-successful-cutting-edge-federal-initiative.html>
5. <http://www.hhs.gov/about/news/2016/03/03/hhs-reaches-goal-tying-30-percent-medicare-payments-quality-ahead-schedule.html>
6. <http://www.hhs.gov/about/news/2015/11/16/cms-finalizes-bundled-payment-initiative-hip-and-knee-replacements.html>
7. <http://www.mcknights.com/news/more-mandatory-bundled-payments-may-be-coming-analysis/article/459974/>

II. MEDICARE POLICY CHANGES

This year Medicare adjusted several payment policies that noteworthy to physicians, their patients, and extended care teams: the “Two-Midnight Rule” was mollified, allowing shorter inpatient stays, but the each case will be reviewed by QIOs for medical appropriateness⁸; for the first time Medicare will cover advance care planning for physicians to discuss end-of-life care and preferences with beneficiaries⁹; physician offices are no longer as attractive for hospital acquisition due to site neutral payment restrictions enacted by the 2016 budget deal¹⁰; a 0.27% reduction to the conversion factor kept Medicare reimbursements near 2015 levels for most physicians¹¹; and an expanded list of reimbursable telehealth services increases opportunities and competition¹². And physicians should expect more to come: Medicare is likely to finalize a requirement that all inpatients and some outpatients have a personalized discharge plans developed within 24 hours of admission or registration¹³.

III. BUSINESS RELATIONSHIPS

2016 means greater clarity and flexibility for physicians participating in health care delivery and payment system reforms. Medicare Shared Savings Program participants received a long awaited formal CMS and OIG waiver relaxing fraud and abuse regulations for ACOs¹⁴ and several easements to the Physician Self-Referral Law (“Stark Law”) became effective¹⁵: physicians may receive a bonus from hospital, Federally Qualified Health Center or rural health clinic for recruiting and retaining non-physician practitioners; the timeshare accommodation reduces the burdens for physicians to lease office space and equipment; and other revisions allow flexibility for structuring ACO arrangements.

8. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-10-30.html>

9. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-10-30.html>

10. <http://docs.house.gov/billsthisweek/20151026/BILLS-114hr-PIH-BUDGET.pdf>

11. <https://www.federalregister.gov/articles/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>

12. <https://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf>

13. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-10-29.html>

14. <https://www.gpo.gov/fdsys/pkg/FR-2015-10-29/pdf/2015-27599.pdf> And <https://www.healthcarelawtoday.com/2015/10/29/oig-and-cms-issue-rule-finalizing-fraud-and-abuse-waivers-for-mssp-acos/>

15. <https://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf> And <http://www.lexology.com/library/detail.aspx?g=a83ac2a6-b30d-4fad-a27e-01deal7c070c>

IV. MEANINGFUL USE

With several recent and pending changes to the Medicare EHR Incentive Programs, it can be cumbersome for physicians to keep the requirements straight. Here's what matters in 2016:

1. 2015 Requirements – Participating physicians must report data for any continuous 90 period in CY 2015 by March 11th.¹⁶
2. 2016 Requirements – Physicians must either:
 - a. a) Apply for a hardship exception by July 1st using a new application that requires less information with a less stringent CMS review¹⁷; or
 - b. b) Submit attestation data¹⁸: new physicians must attest to meeting 10 new objectives for any continuous 90 day period and may report the results by October 1, 2016 or by February 28, 2017 (latter reporting avoids 2018 payment adjustments but not 2017). Returning physicians must meet the 10 objectives for the full 2016 calendar year and report by February 28, 2017.

And while meeting existing Meaningful Use requirements, physicians should be aware that CMS is redesigning the program to shift from “measuring clicks to focusing on care”¹⁹ as part of Medicare’s new physician payment methodology, the Merit-Based Incentive Payment System (MIPS), under development in 2016. (See Medicare Reimbursements and Value Based Payments for more detail.)

Additionally, physicians should be aware that CMS is facing pressure to change the near universal mandate that providers attain Meaningful Use Stage 3 in 2018.²⁰ A change could be included in the MIPS rule or a separate rule this year.²¹

V. ICD-10

The ICD-10 transition occurred without major disruptions last October, but during the first quarter providers should encounter the first wave of ICD-10 denials. That means 2016 will be an education year as clinical teams get a better sense for medical necessity requirements and common coding nuances. The claims auditing and quality reporting flexibility offered by Medicare and private payers expires in October, so providers and their revenue cycle teams have a short window to learn the 69,823 diagnostic codes and 71,924 procedural codes.²²

16. <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms>

17. <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms> and https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/paymentadj_hardship.html

18. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016_EPWhatYouNeedtoKnowfor2016.pdf

19. <http://blog.cms.gov/2016/01/19/ehr-incentive-programs-where-we-go-next/>

20. <http://www.fierceemr.com/story/hospitals-hhs-reconsider-meaningful-use-stage-3/2016-01-15>

21. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-06-2.html>

22. <http://www.roadto10.org/ama-cms-press-release/>

VI. MEGA-MERGERS

This year all eyes will be on the insurance industry's proposed mega-mergers: Aetna's \$37 billion bid for Humana and Anthem's \$54 billion acquisition of Cigna. The Department of Justice and Federal Trade Commission will undertake a national level antitrust review, announcing outcomes in the middle or second half of 2016.²³ Independently, each State's insurance commissioner and attorney general will scrutinize these deals for antitrust and consumer protection concerns before announcing results on a rolling-basis beginning in the first quarter²⁴. Physicians should note at the State level there's greater opportunity to contribute viewpoints with public hearings and often clearer windows for smaller advocacy coalitions. Moreover States often seek concessions responsive to local markets, including premium or reimbursement restrictions, provider access requirements, quality improvement efforts, and divestiture of lines of business. And State regulators also could outright block a merger from occurring within the State.

Not to be overlooked is the FTC's intervention to block hospital mergers (e.g. Penn State Hershey Medical Center and Pinnacle Health System, Cabell Huntington Hospital and St. Mary's Medical Center, and Advocate Health Care and Northshore University Health System)²⁵ and physician practice acquisition (e.g. Keystone Orthopedic Specialists²⁶) throughout the country.

VII. PATIENT ENGAGEMENT

Patient engagement will be even more pressing for physicians in 2016 as patient financial responsibility increases (deductibles are up 67% from 2010 to 2015 for employer sponsored coverage²⁷) and health expenses eat up greater percent of household income (26% of households had problems paying medical bills last year²⁸). Physicians will be tasked with formulating sustainable treatment plans to meet patients' constricted budgets and challenged to coordinate care with more partners as patients seek alternative or lower cost treatments locations. And the complexities of narrow networks will continue to put physicians and their support teams in ambassador roles explaining coverage limits to patients. Some network adequacy relief may be on the way for providers should HHS finalize its proposal for quantifiable network adequacy metrics for 2017 Exchange insurance plans or if States adopt recent NAIC model legislation.²⁹

23. <https://www.politicopro.com/health-care/story/2016/01/state-regulators-will-take-a-tough-look-at-insurance-mega-mergers-089720>

24. <http://www.modernhealthcare.com/article/20151212/MAGAZINE/312129969>

25. <http://www.modernhealthcare.com/article/20151218/NEWS/151219865>

26. <https://www.ftc.gov/news-events/press-releases/2015/10/two-pennsylvania-orthopedic-practices-settle-ftc-charges-merger>

27. <http://kff.org/report-section/ehbs-2015-summary-of-findings/>

28. <http://kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/>

29. <http://healthaffairs.org/blog/2015/11/23/the-2017-benefit-and-payment-parameters-proposed-rule-drilling-down/>

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VIII. SCOTUS & FEDERAL COURT CASES

There are several prominent court cases that the physician community should track: the Supreme Court's ruling in *Gobeille v Liberty Mutual Insurance Company*³⁰ clarified that self-funded ERISA plans are not required to report to a State's all-payer claims database, limiting the breadth of claims and reimbursement data made transparent by sixteen states' APCDs.³¹ And in *Universal Health Services v US ex rel.* the Court will decide whether providers are implicitly certifying compliance with all regulations when requesting Medicare and Medicaid reimbursement, and thus are violating the False Claims Act when not in compliance and submitting claims.³²

On the Federal level, physicians should follow Teladoc's antitrust challenge to the Texas Medical Board requirement for an in-person visit prior to a virtual one since the result will have national implications for State Medical Boards treatment of telemedicine.³³ There are two high profile False Claims Act Cases for physicians to keep on their radar too: In *Michaels v. Agape Senior Community* the court will address whether statistical sampling can continue to be used to establish liability and damages in a False Claims Act cases³⁴ and the two-part *US v AseraCare Inc* will decide the validity of diagnoses and alleged knowledge of false Medicare claims.³⁵

For more information on physician pressure points, reach out to one of the authors, Jimmy W. Burnett (jimmy.burnett@navigant.com) or Dr. Scott B. Ransom (scott.ransom@navigant.com).

30. <http://www.scotusblog.com/case-files/cases/gobeille-v-liberty-mutual-insurance-company/>

31. <http://www.apcdouncil.org/state/map>

32. <http://www.scotusblog.com/case-files/cases/universal-health-services-v-united-states-ex-rel-escobar/>

33. <http://www.modernhealthcare.com/article/20151214/NEWS/151219924>

34. <http://www.law360.com/articles/712001/4th-circ-fca-statistical-sampling-case-is-one-to-watch>

35. <http://www.law360.com/articles/734842>

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