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CONGRESSIONAL ACTION

ACA replacement faces criticism as GOP divisions widen

The long-awaited Republican replacement for the Affordable Care Act (ACA) was finally unveiled March 7, but the resulting bill has divided Republicans in the House and Senate. Dubbed The American Health Care Act (AHCA), the replacement plan was released by committees in the House of Representatives and quickly received a damaging assessment from the Congressional Budget Office (CBO).

The CBO, often referred to as a bipartisan "scorekeeper" for legislation proposed by both parties, assessed that the AHCA would result in 14 million Americans losing their insurance in 2018. The CBO projects that figure to grow to 24 million by 2026, though the agency also estimates that the bill would also reduce federal deficits by $337 billion over the next decade, largely the result of slashing the ACA's Medicaid expansion.

More conservative members of Congress argue that the AHCA strongly resembles the ACA and doesn't go far enough in terms of a true replacement. More moderate Republicans, in the wake of the CBO analysis, have expressed concern that the AHCA would quickly alienate voters who lose their insurance, and that the bill doesn't fulfill the promises made by President Donald J. Trump during his campaign. Trump had stated that the ACA replacement would cover the same number of Americans, if not more, while also reducing premiums.

Core elements of the AHCA first appeared in past Republican proposals, including A Better Way, the plan by House Majority Leader Paul Ryan (R-Wis.) and The Empowering Patients First Act drafted by former Rep. Tom Price (R-Ga.), now the HHS Secretary.

"These ideas have been out there, some of them go as far back as the Republican proposals during the creation of the ACA in 2009," says Jack Hoadley, research professor at Georgetown University in Washington, D.C. "For Republican leaders and the rank-and-file, the issue is going to be what their criteria is for an acceptable program, in terms of the number of people insured, what the costs are, and how those costs will be paid."

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Replacement looks similar to ACA

But it's also true that the replacement plan does resemble the ACA, Hoadley says. Below are highlights of the AHCA:

• **Popular provisions preserved.** People with pre-existing conditions would continue to be protected from higher rates, though people who experience a lapse in coverage could be charged higher premiums when they reenroll. Also, the AHCA copies the ACA's provision allowing young people to stay on their parents' plans until they turn 26.

• **Medicaid expansion stays until 2020.** The AHCA would preserve the ACA's massive expansion of the Medicaid program until Jan. 1, 2020. After that date, Medicaid would stop new enrollments and allow existing enrollees to attrition out whenever their income rose above the minimum. The AHCA would also set a per-person limit on Medicaid benefits for the first time in the history of the program, a move that would eventually shift a major chunk of the financial burden to the states. Even so, this temporary preservation of Medicaid is the single biggest change from previous Republican proposals. The Ryan plan would have significantly reduced the scale of federal contributions to Medicaid, while the Price plan completely eliminated the Medicaid expansion.

• **Individual mandate goes away.** The AHCA immediately eliminates the ACA's individual mandate, which requires individuals to purchase health insurance or pay a tax penalty. This measure would likely reduce the number of insured because there would be no cash incentive for the young and healthy to buy insurance.

• **Keeps ban on lifetime benefit cap.** Just like the ACA, the AHCA prevents insurance companies from putting a dollar cap on maximum benefits for an insured individual. While most people wouldn't hit such caps, some very sick individuals who need significant care could've potentially hit the cap and lost benefits during a major illness without this provision.

• **Mandatory benefits pared back, but remain.** In another unexpected parallel to the ACA, the AHCA continues to require a minimum set of benefits to be covered by every health insurance plan. The AHCA reduces some of the more generous mandatory benefits, but the fact that a mandate remains at all has been seen as a surprise.

• **Age-based tax credits.** Unlike the ACA's income-based tax credits, which help offset the cost of insurance premiums, the AHCA relies on age-based tax credits which ignore income. The result is a more regressive approach to subsidizing the costs of health care that wouldn't be nearly as generous to the poor, but would reduce the overall costs of the program.

Vote expected soon

For his part, President Trump appears open to having the end product be tweaked by the various Republican factions. He described the bill as being open to "review and negotiation" in a March 7 Tweet. The entire process is expected to move quickly; Rep. Ryan has promised that the AHCA bill would be up for a vote in a matter of weeks.

"President Trump talked about ACA repeal at a very rhetorical level, saying 'we're going to keep what's good and get rid of what's bad,'" says Hoadley, the Georgetown policy expert. "But now that we're down to a policy level, there's going to be conflicts between the Trump approach and what can pass Congress."

MEDICARE RULES

MIPS: Explaining Clinical Practice Improvement Activities

The first-ever reporting period for the Merit-based Incentive Payment System (MIPS) is now in full swing, but one of the program's core components remains mysterious. "Clinical improvement activities" or CPIA is one of the four MIPS components, and it may be the most crucial component in 2017.

This year has been designated as a MIPS "transition year" by CMS, which means among other things that of the four MIPS components, only three will count toward your overall MIPS score. That score will be used to determine whether your providers will receive payment bonuses, penalties, or no change for 2019, the MIPS payment year that 2017 performance will affect. CPIA is one of the three categories that will count.

The "Cost Performance" category of MIPS will not count toward your score in 2017, though CMS will still calculate your cost score and share it with you. Of those three

components that count, CPIA is the most intriguing. The other components are "Quality performance" which is nearly identical to quality reporting under the Physician Quality Reporting System (PQRS), and "Advancing care information" which is the counterpart to the EHR meaningful use reporting program.

These are well understood by practices, being derived from PQRS and meaningful use, both of which the industry has been dealing with for many years.

What is CPIA?

Clinical practice improvement is not new either, but under MIPS it has grown to encompass 92 possible improvement activities. Some, such as "diabetes screening" and "depression screening," are more relevant to primary care than specialties. But there are a wide variety of CPIA measures to choose from, including measures that are deliberately not specialty-specific.

The 92 total activities are split into nine different subcategories, as follows:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an Alternative Payment Model (APM)
- Achieving health equity
- Emergency preparedness and response
- Integrated behavioral and mental health

You may choose activities from any of the categories. Because 2017 is a transition year, the bare minimum to satisfy MIPS reporting and avoid a payment penalty in 2019 is performing a single CPIA and reporting it. You could also get away with reporting one quality measure to guarantee a flat update in 2019.

It's important to remember that MIPS is scored on a point system rather than a simple pass/fail metric for each component. Even for 2019, the first payment year, your providers will receive a MIPS composite score that is a number from 0 to 100.

Two weights: CPIAs are not all equal

One fact about CPIAs that has received little attention amid all the MIPS guidance and preparation is that not all measures are worth the same. CPIA measures are weighted differently by CMS. The agency maintains an interactive list of all CPIA measures with detailed descriptions online here.

Most CPIA measures have "medium" weight and are worth 10 points. Fourteen of the 92 total CPIA measures have "high" weight and are worth 20 points. These points do not directly translate to the MIPS composite score, but are instead added to a total CPIA point bank. That bank is then used to calculate your MIPS composite score together with points from the other MIPS categories. In a regular, non-transition

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PRACTICE MANAGEMENT

How to show CMS your practice actually did CPIA

The language that CMS uses to describe Clinical Practice Improvement Activities (CPIA) is very vague, as pointed out in the article above. CMS is especially silent on what practices and providers must do to prove that they actually performed the CPIA measures they will claim to for the purposes of the Merit-based Incentive Payment System (MIPS) in 2017.

"The vague wording on each activity makes it open to interpretation, but I actually think this is a good thing," says Michael Brohawn, FACMPE, practice administrator at Orthopaedics East & Sports Medicine Center in Greenville, NC. "It's a good thing for practices because it's more open-ended, and CMS has also said that they're not going to issue any more guidance on CPIA this year."

That choice may be deliberate on the part of CMS, to give practices latitude during 2017, a MIPS transition year, Brohawn says. The "wait-and-see" attitude could also give CMS a chance to observe how much effort is required for practices to implement various CPIA, so that the agency can write better guidance in future years.

Brohawn's practice has applied to participate in Medicare's Clinical Practice Improvement Activities Study, which will collect information from 42 provider organizations across the country to further assist the agency in issuing CPIA guidance.

One practice's choices for CPIA

Brohawn's practice will be implementing three CPIA measures in 2017:

1. Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan (high weight). Already in effect at Brohawn's practice, which conducts quarterly patient surveys and makes changes to their workflow and patient service accordingly.

2. Use of decision support and standardized treatment protocols (medium weight). Also already in use at Brohawn's practice, where the physicians have created consensus protocols that are written down for each specific condition they treat, such as torn rotator cuffs. The protocol includes procedure type, tools, medication usage, and post-procedure therapy scheduling.

3. Implementation of improvements that contribute to more timely communication of test results (medium weight). This CPIA measure would be new to Brohawn's practice (see below).

The third measure, to improve timely communication of test results, hinges on the word "timely," which CMS has not defined beyond simply that word itself, Brohawn says. "We plan to sit down with our staff and see what our baseline is for calling patients with test results," he says. Eventually they will produce a report on how to improve their communication.

In case of audit, prove that you did CPIA

CMS has already shown that it doesn't simply hand out incentive monies based on attestations alone. The agency continues to perform audits of attestations for its EHR Meaningful Use Incentive Program, and there's no reason to think CMS won't come up with a similar strategy for MIPS bonus payments, Brohawn believes.

To be clear, CMS has not yet announced any specific details for a MIPS auditing program, though officials have promised that there will be audits at some point. Information on future MIPS will be provided via additional rulemaking. "When that happens, it won't be good not to be able to produce any evidence, even though CMS hasn't said what will constitute evidence for CPIA," Brohawn says.

His practice is taking a proactive approach. For each of the three CPIA measures described above, Brohawn has proof – copies of patient surveys, internal memos, and the final reports that explain what steps the providers and staff are taking to improve their practice.

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MIPS year, CPIA is worth a maximum of 60 points, which can be arrived at with any combination of medium and high-weight measures.

The following CPIA measures have high weight (20 points). **Bold measures** stand out as being the most widely accessible regardless of your providers' specialties. CMS offers a definition of each measure below, which you can read in full on the agency's CPIA measure site.

- Anticoagulant management improvements
- **Collection and follow-up on patient experience and satisfaction data**
- Consultation of the Prescription Drug Monitoring program. Defined by CMS as the "collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan."
- **Engagement of new Medicaid patients and follow-up.** Defined by CMS as "seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare."
- Glycemic management services
- Implementation of co-location PCP (primary care) and MH (mental health) services
- Implementation of integrated PCBH (primary care behavioral health) model
- Participation in a 60-day or greater effort to support domestic or international humanitarian needs
- Participation in CAHPS or other supplemental questionnaire
- Participation in systematic anticoagulation program
- **Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record.** Defined by CMS as making sure all MIPS-eligible clinicians and entities have 24/7 access to your provider's records for a patient, so that any urgent or emergent care issues can be handled.
- RHC (rural health center), IHS (Indian health services) or FQHC (federally qualified health center) quality improvement activities
- TCPI (Transforming Clinical Practice Initiative) participation
- Use of QCDR (qualified clinical data registry) for feedback reports that incorporate population health

New DoctorsManagement clients

Client	Services provided
Pediatric practice, LA	Feasibility study
Family practice, LA	Monthly practice management
Dermatology group, SC	Monthly practice management
Concierge medicine, TX	Hourly consulting
Nephrology practice, FL	Feasibility study
ENT group, OR	Practice start-up
Dermatology practice, VA	Practice start-up
ENT group, VA	OIG compliance plan development
Hospital system, FL	Coding and auditing services
Senior living, FL	Auditing services
Hospital system, GA	Auditing services
Home health group, AL	Auditing services
Vascular group, MD	Annual audit
Psychiatry practice, KY	Annual audit
Orthopedic and sports medicine, NY	Annual audit

Documenting and scoring CPIA

CMS hasn't released much explicit guidance on what type of documentation a provider would be required to maintain to prove that a CPIA measure was actually reported accurately. However, some practices aren't being deterred and have found their own ways to document CPIA compliance (see related story, pg.. 5) CPIA measures can be reported via multiple methods, including via data registry. Regardless of reporting method, each participating provider must attest that they completed the CPIA measure.

Of the maximum possible CPIA score of 60 points, 40 points will be required to satisfy MIPS reporting in a regular, non-transition year (i.e. 2019 and beyond). The CPIA category can contribute a total of 15 points to your overall MIPS composite score (being weighted at 15% of the score). Therefore if a provider earns 60 CPIA points, that provider is guaranteed to receive a minimum MIPS composite score of 15 points, from CPIA alone. CMS may decide to increase or decrease the weight of CPIA towards the overall MIPS score in future years.

COMPLIANCE

6 tips for complying with incident-to rules

You could improve your patient volume and give your physicians more flexibility by having your non-physician practitioners bill under Medicare's "incident-to" guidelines. These rules, which some private insurers have also adopted, allow nurse practitioners, physician assistants, and physical and occupational therapists to bill for services under the name and identifier of supervising physicians.

Medicare reimburses physicians at the full fee schedule rate, but only reimburses non-physician providers at 85% of the fee schedule rate. By allowing non-physician providers to bill for outpatient office visits at the full rate, physicians are free to see new patients or more complex cases, or perform surgery.

Other common in-office procedures, such as wound debridement or drug injections, can also be performed by a non-physician and billed incident-to, provided they follow incident-to rules (see below).

Incident-to tips and rules

Below are the most important incident-to rules along with tips to comply with them.

1. **Outpatient only, and payer-specific.** Incident-to rules only apply to services rendered in the outpatient or office setting. Medicare and some, but not all, private insurance companies allow incident-to billing. For example, Anthem has its own incident-to policy, mostly copied from CMS.

2. **Services must be part of an existing plan of care.** This is the single most important and often confused requirement for incident-to services. A plan of care for the patient must have first been created by the physician, or else the patient cannot be seen under incident-to guidelines. This means that the more expansive and well-documented the plan of care, the better, because the non-physician will have more latitude to manage the patient. **Example:** If a patient is recovering from an arthroscopic repair of a torn meniscus, and the plan of care includes language that supports increasing dosage for pain management medication or altering the type of medication as needed, then the non-physician may make these changes and still

bill the service under the physician. If the plan of care did not specify what to do when drug changes are needed, the non-physician could not make those alterations and still bill under the physician.

3. **No new patients.** Because a plan of care created by a physician must exist for the non-physician to follow (and have his/her services to be "incidental" to), no new patients can be seen by a non-physician provider.

4. **No new problems or changes to plan of care.** The same logic applies to new problems or an existing problem with an exacerbation that requires altering the plan of care. Whenever the plan needs to change, the physician must take over the visit in order for the visit to be billed under the physician's identifier at the full fee schedule rate. Alternatively, the non-physician can assume responsibility for the visit and bill under his or her identifier at 85% of the fee schedule rate.

5. **Physician supervision required.** A physician must be available in the office suite if needed by the non-physician provider for any reason. He or she doesn't have to be in the exam room, but does need to be immediately physically available (i.e. not on lunch break or only available via phone). This supervising physician does not need to be the same physician who created the plan of care.

6. **Plan of care needs to be updated and physician must stay involved.** The physician must stay involved in the care of patients who are seen incident-to, and is expected to update the plan of care as needed over time. The plan itself must be readily accessible in case a payer decides to request your documentation for an audit.

Are incident-to rules too strict?

If you are able to comply with the rules above, you can find that your practice can see more patients without losing any revenue. But the rules aren't easy for many practices, and there's still one problem that has nothing to do with Medicare's rules: Patient experience. Many patients expect to see the physician and aren't happy being seen by a non-physician provider whom they perceive, often unfairly, as being less capable than an MD in treating their problems. To navigate this issue, you can point out to patients that the non-physician provider can usually see them sooner than your physicians, who are seeing new patients or performing surgery.

CODING

New in 2017: Modifier 95 and telemedicine codes

There's a new modifier for telehealth services rendered to patients who are on private insurance rather than Medicare. Modifier **95** (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) can be appended to E/M visit codes (**99201-99205** for new patients, **99211-99215** for established patients).

This change doesn't affect Medicare, which will still rely on the existing modifier **GT** (services delivered via interactive video and video telecommunication systems). The biggest obstacle from a Medicare standpoint continues to be the issue of the "originating site," which is the physical location of the patient.

Telehealth would be a game-changer if the originating site could be a patient's home; instead CMS continues to require that the originating site be outside of major metropolitan areas (as defined by metropolitan statistical areas or MSAs). The agency provides an online tool to determine whether an office or hospital location qualifies as an originating site for telehealth.

CMS pays a facility fee to the facility or office serving as the originating site (reported using the HCPCS code **Q3014**), and professional fee based on the CPT code supported to the provider who renders the E/M service. That E/M code receives either modifier GT or 95 depending on payer.

Another change for 2017 is the new place of service (POS) code created specifically to represent telehealth. The new code is 02 and defined as "Telehealth: the location where health services and health-related services are provided or received, through telehealth telecommunication technology."

Private payers ahead of the curve

Fortunately, private insurance companies tend to be more progressive than CMS in paying for telemedicine. Many, though not all, private payers allow the originating site to be a patient's home. Part of the reason are telemedicine "parity" laws passed in many states require payers operating in their jurisdiction to reimburse telemedicine E/M services the same way they would in-person services.

The list of states with such a law is below:

- Arizona
- Arkansas
- California
- Colorado
- Delaware
- Georgia
- Indiana
- Kentucky
- Louisiana
- Maine
- Maryland
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nevada
- New Hampshire
- New Mexico
- New York
- Oregon
- Oklahoma
- Tennessee
- Texas
- Vermont
- Washington state
- Washington, D.C.

Several other states have parity bills in the process of being signed. The American Telemedicine Association (ATA) maintains trackers on its website. Coverage will vary based on payer, though all payers in the listed states above must reimburse telemedicine for patients whose plans cover the service. You will also need to check that the payer doesn't follow Medicare's highly restrictive "originating site" definition. Be sure to utilize modifier 95 properly in these cases.