SGR: RIP
Nancey K. McCann/Ashley McGlone

No Relevant Financial Relationships with Commercial Interests
Priority Issues for Ophthalmology

- Implementation of MACRA (Quality Payment Program)
- Minimizing Drastic Cuts to Retina and Glaucoma Codes
- Cataract Episode Grouper
- 21st Century Cures Initiative
- Office-Based Surgical Suite Cataract Surgery
- Repeal IPAB
- Private Contracting/Patient Shared Responsibility
- Drug Compounding
- Cleaning and Sterilization Guidelines
- Proposed Health Insurer Mergers – possible anti-trust issue
Common Theme

Bi-partisan effort aimed at moving Medicare payment into a system based on outcomes, quality, and efficiencies

- Goal of tying 30% of traditional or fee-for-service Medicare payments to “quality or value” through alternative payment models by the end of 2016 (already achieved); 50% of payments to these models by the end of 2018.
Medicare Access and CHIP Reauthorization Act (MACRA)

Overview

- Developed in bipartisan, bicameral process over 2+ years
- Supported by over 750 national and state-based physician organizations
- Passed House of Representatives March 26, 2015- 392-37
- Passed Senate April 14, 2015 – 92-8
- Permanently eliminates the SGR, which has been producing Medicare physician payment cuts annually since 2002 and provides for 5 years of a 0.5% update.
- Implements new payment system that ties reimbursement to performance and offers two payment pathways: Modified fee-for-service model (MIPS) and Advanced Alternative Payment Models (APMs)
Medicare Access and CHIP Reauthorization Act (MACRA) Overview

• **MIPS - Merit-Based Incentive Payment System**
  – Consolidates the current quality reporting programs, PQRS, VBPM, Meaningful Use and adds clinical practice improvement activities, into a new program - beginning in 2019, based on 2017 reporting.

• **APMs – “Advanced” Alternative Payment Models**
  – Based on participation in an APM and meeting certain thresholds.
  – Will be exempt from MIPS and will receive a 5% bonus payment for six years.
MACRA Overview (cont.)

• Global Surgical Codes Protected
  – CMS Policy would have transitioned all 10- and 90-day global codes to 0-day
  – Analysis showed that ophthalmology would have been the hardest hit specialty

• Standard of Care Protection Act
• Indefinite Opt-Out for Private Contracting
• EHR’s required to be “interoperable” by 2017
## MACRA Improvements vs. Prior Law

<table>
<thead>
<tr>
<th>Then</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Negative Updates for the foreseeable future</td>
<td>• Modest, but positive updates for 5 years, and then again in 2026 and beyond</td>
</tr>
<tr>
<td>• Multiple overlapping, rigid, and sometimes contradictory reporting and penalty programs</td>
<td>• Consolidated Merit-Based Incentive Payment System (MIPS) with more flexibility, potential for significant bonuses, lower maximum penalties</td>
</tr>
<tr>
<td>• Limited support for new payment and delivery models through Centers for Medicare and Medicaid Services Innovation</td>
<td>• Enhanced technical and financial support for small practices, transitional payments for new models, funding for quality measures, more timely physician access to performance data</td>
</tr>
</tbody>
</table>
### Physicians Have Choices

<table>
<thead>
<tr>
<th>FFS</th>
<th>APMs</th>
</tr>
</thead>
</table>
| • 0.5% July 2015 thru 2019; 0% 2020-25;  
• After that: those in APM get 0.75; others get 0.25%  
• Former reporting programs consolidated into MIPS with greater flexibility  
• Penalty risks reduced, potential bonuses added  
• Benchmarks set prospectively, more timely feedback on performance | • Physicians role in creating new models specified  
• 5% update bonuses for 6 years aides transition to new 2-sided risk models  
• Demonstrated savings will produce higher payments  
• Participants exempt from MIPS |
### 2019 Penalties Compared

<table>
<thead>
<tr>
<th>Prior Law</th>
<th>2019 Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS</td>
<td>-2%</td>
</tr>
<tr>
<td>MU</td>
<td>-5%</td>
</tr>
<tr>
<td>VBM</td>
<td>-4% or more*</td>
</tr>
<tr>
<td><strong>Total Penalty Risk</strong></td>
<td><strong>-11% or more</strong>*</td>
</tr>
<tr>
<td>Bonus Potential (VBM only)</td>
<td>Depends on the size and number of penalties</td>
</tr>
</tbody>
</table>

*VBM has been in effect for 3 years, and penalty risk has increased in each of these years; there are no floors on penalties. 2019 number would not have been issued until November 2018. Budget neutral funding for bonuses.

<table>
<thead>
<tr>
<th>MIPS Factors</th>
<th>2019 Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Penalty Risk</strong></td>
<td><strong>Capped at -4%</strong></td>
</tr>
<tr>
<td>Bonus Potential</td>
<td>As high as 4% with the potential to earn as much as 3 times that amount, in addition to a potential 10% for exceptional performers</td>
</tr>
</tbody>
</table>
What is MIPS?

- Quality (50%)
- Resource Use (10%)
- Advancing Care Information (25%)
- Clinical Practice Improvement Activities (15%)

= Composite Score
Merit-Based Incentive Payment System (MIPS)

- Streamlines existing PQRS, VPBM and EHR Meaningful Use programs
  - Existing penalties sunset at the end of 2018
- Assesses the performance of EPs based on 4 categories:
  - Quality
  - Resource Use
  - Advancing Care Information (EHR)
  - 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 25th percentile)
MIPS Maximum Payment Adjustments

<table>
<thead>
<tr>
<th>MIPS Maximum Negative Payment Adjustments by Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
</tr>
<tr>
<td>4%</td>
</tr>
</tbody>
</table>
Implementation of MACRA (Quality Reporting Program)

• Proposed rule released on April 27
• 60 day comment period – June 27th
• Incorporates some of the flexibility and reduced reporting burdens advocated by ASCRS and the medical community
Implementation of MACRA (Quality Reporting Program)

- Individual or Group Reporting
- Continues two-year look back
Program Modifications and Weights for Each of the Four Components

• Quality (50% of total score in year 1)
  ➢ Report a minimum of six measures, with at least one cross-cutting measure and an outcome measure, if available. Otherwise, provider would report one additional “high quality” measure.

• Cost (10% of total score in year 1)
  ➢ Includes two of the cost measures previously used in VBPM program: total per capita costs for all attributed beneficiaries and Medicare spending per beneficiary.
  ➢ Attribution method unchanged – two step process
  ➢ Episode-based measures will be used to evaluate resource use, as applicable.
  ➢ Episode for cataract surgery included with no details
Program Modifications and Weights for Each of the Four Components

- Advancing Care Information (25% of total score in year 1)
  - Submit data for a full calendar year reporting period.
  - Comprised of a score for participation and reporting 6 objective and their measures (base score – up to 50 points) and a score for reporting at various levels above the base score (performance score – up to 80 points)
  - Performance score – score for reporting above the base level in objectives and measures for patient electronic access, coordination of care through patient engagement, and health information exchange.
Program Modifications and Weights for Each of the Four Components

- Clinical Practice Improvement Activities (CPIAs) (15% of total score in year 1)
  - Work toward a total of 60 points by selecting CPIAs.
  - Select activities from a list of more than 90 options, such as care coordination, beneficiary engagement, and patient safety.
  - Medium level activities worth 10 points; high level activities worth 20 points.
  - CPIA performed for at least 90 days during the performance period.
Reform EHR/ Meaningful Use

• ASCRS worked with medical community to reshape the program before it was incorporated into MIPS
• Guiding Principles
  – Reduce measure thresholds
  – Don’t penalize physicians for actions of other physicians or patients out of their control
  – Develop measures meaningful to specialists
  – Remove “all or nothing” approach
  – Focus on interoperability
  – Expand hardship exemptions flexibility

  ❖ Successful!!!!!
### Changes from Medicare EHR Incentive Program to Advancing Care Information Performance Category

<table>
<thead>
<tr>
<th>Existing Medicare EHR Incentive Program Requirements</th>
<th>New Proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must report on all objective and measure requirements, including Clinical Decision Support and Computerized Provider Order Entry.</td>
<td>Streamlines measures and emphasizes interoperability, information exchange, and security measures. Clinical Decision Support and Computerized Provider Order Entry are no longer required.</td>
</tr>
<tr>
<td>One-size-fits-all—every measure reported and weighted equally</td>
<td>Customizable—Physicians or clinicians can choose which measures best fit their practice.</td>
</tr>
<tr>
<td>All-or-nothing EHR measurement and quality reporting</td>
<td>Flexible—multiple paths to success</td>
</tr>
<tr>
<td>Misaligned with other Medicare reporting programs</td>
<td>Aligned with other Medicare reporting programs. No need to report quality measures as part of this category.</td>
</tr>
</tbody>
</table>
Advancing Care Information Base Score

- Protect Health Information (yes required)
- Electronic Prescribing (numerator/denominator)
- Patient Electronic Access (numerator/denominator)
- Coordination of Care through Patient Engagement (numerator/denominator)
- Health Information Exchange (numerator/denominator)
- Public Health and Clinical Data Registry Reporting (yes required)
Advancing Care Information Performance Score

- Patient Electronic Access
- Coordination of Care Through Patient Engagement
- Health Information Exchange
Advancing Care Information (ACI) Composite Score Calculation

**BASE SCORE**
- Makes up to **50 Points** of the total ACI performance category score

**PERFORMANCE SCORE**
- Makes up to **80 Points** of the total ACI Performance Category Score

**BONUS POINT**
- Up to **1 Point** of the total ACI Performance Category Score

**COMPOSITE SCORE**
- Earn 100 or more points and receive **Full 25 Points** in the ACI Category of MIPS Composite Score

Earn > **100 Points**, overall MIPS Score declines proportionally
## Advancing Care Information

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>ePrescribing</td>
</tr>
<tr>
<td>Patient Electronic Access*</td>
<td>Patient Access</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td></td>
</tr>
<tr>
<td>Coordination of Care Through Patient Engagement*</td>
<td>View, Download, and Transmit (VDT)</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td></td>
</tr>
<tr>
<td>Patient-Generated Health Data</td>
<td></td>
</tr>
<tr>
<td>Health Information Exchange*</td>
<td>Exchange Information with Other Physicians or Clinicians</td>
</tr>
<tr>
<td>Exchange Information with Patients</td>
<td></td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td></td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Immunization Registry Reporting</td>
</tr>
<tr>
<td>(optional) Syndromic Surveillance Reporting</td>
<td></td>
</tr>
<tr>
<td>(optional) Electronic Case Reporting</td>
<td></td>
</tr>
<tr>
<td>(optional) Public Health Registry Reporting</td>
<td></td>
</tr>
<tr>
<td>(optional) Clinical Data Registry Reporting</td>
<td></td>
</tr>
</tbody>
</table>

*these measures may be selected for the performance score
APM’s – Advanced Alternative Payment Models

• Encouraging Advanced Alternative Payment Model (APM) participation
  – EPs who receive significant share of revenues (25% in 2019, 2020) through an APM that involves:
    • Risk of financial loss;
    • A quality measure component; and
    • Requirement that a majority of participating clinicians are using certified EHR technology
  – Will receive 5% bonus each year from 2019-2024.

• Excluded from MIPS and most EHR Meaningful Use requirements

• Two types of APMs – Advanced APMs and Other Payer Advanced APMs
APM’s – Alternative Payment Models

- Advanced APMs include ACOs (2-sided risk), medical homes, and episode payment models
- Other Payer APMs include payment arrangements under any payer other than traditional Medicare - including Medicare Advantage and other Medicare-funded private plans.

- Medicare Advantage counts toward APM thresholds, but not towards the payment calculation in the Alternative Payment Model Incentive Payments program.
APM’s – Advanced Alternative Payment Models

• For year 1 –
  ➢ Must derive at least 25% of payment amounts or include 20% of patients from the APM to receive bonus payment for qualified participation. (increases in following years)
  ➢ Most anticipate many clinicians will participate to some extent, but not meet the law’s requirements for sufficient participation in most advanced models.
  ➢ Allows clinicians to switch between components of the Quality Payment Program based on what works best for their practice and patients.
Partially Qualifying APM Participant

- A partial qualifying APM participant is defined as an EP who does not meet the thresholds established but meets slightly reduced thresholds.
- Partial qualifying APM participants do not receive the 5% incentive payment.
- They can participate in MIPS but are held harmless if they do not participate in MIPS.
- To be a partial qualifying APM participant the clinician must receive 20% of their Medicare payments through an Advanced APM or must see 10% of their Medicare patients through an Advanced APM.
### Advanced APM Participation Thresholds

#### Requirements for Incentive Payments for Significant Participation in Advanced APMs
(Clinicians must meet payment or patient requirements)

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024 or later</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage of Payments through an Advanced APM</strong></td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Percentage of Patients through an Advanced APM</strong></td>
<td>20%</td>
<td>20%</td>
<td>35%</td>
<td>35%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
“Misvalued” Codes Initiative

• ABLE Act passed in late 2014 - accelerated an initiative previously included in an earlier SGR “patch” to revalue certain “misvalued” codes.
• Moved up the timeline to 2016-2018 and set a 1% target from misvalued savings for 2016 and a 0.5% target in savings for 2017 and 2018.
• If target is met – savings are redistributed to other services and excess savings carry forward.
• Otherwise – across-the-board cuts apply.
• Sets screens to identify potentially misvalued codes.
• Secretary given wide discretion to collect information (surveys) to set the work and practice expense RVUs.
• 2016 Medicare Physician Fee Schedule included steep cuts to certain retina and glaucoma procedure cuts – based work value on time alone, ignoring intensity.
• ASCRS partnering with ophthalmic community to minimize the cuts, seeking Congressional involvement;
• Bipartisan House letter led by Reps. Peter Roskam (R-IL) and John Lewis (D-GA) requesting CMS reconsider cuts.
• Bipartisan Senate letter led by Senators Charles Grassley (R-IA) and Sherrod Brown (D-OH) requesting CMS reconsider cuts.
21\textsuperscript{st} Century Cures Initiative

- Bipartisan effort by the House Energy and Commerce Committee to speed access to new drugs and devices.
- H.R. 6, the 21\textsuperscript{st} Century Cures Act, passed the House 344-77 on July 10.
- 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
21st Century Cures Act

- H.R. 6 Includes:
  - Increased funding for FDA and NIH
  - Streamlining and modernizing clinical trials and approval process
  - EHR interoperability
  - Enhanced valid scientific evidence
  - Medicare Pharmaceutical and Technology Ombudsman
  - Enhanced combination products review
  - Improvements to the FDA Advisory Committee Process
  - Off-label communications
Senate Innovation Effort

- Senate Health, Education, Labor and Pensions (HELP) Committee began complementary effort on the Senate side in 2015
- HELP has passed several smaller bills, rather than one similar to H.R. 6
- Partisan disagreements on funding for NIH and FDA;
- More focus on Health IT – S. 2511, Improving Health Information Technology Act
  - Instructs CMS to address provider regulatory burden
  - Encourages interoperability and punishes data-blocking
  - ASCRS provided input on draft legislation
- Other issues covered:
  - Creating a priority review process for devices
  - Strengthening FDA and NIH workforce
  - Precision medicine
- July 4th - Goal of reconciling different House and Senate versions and final passage.
Contact Lens Consumer Health and Protection Act (S. 2777)

- Sponsored by Sens. Bill Cassidy, MD (R-LA) and John Boozman, OD (R-AR);
- Amends the Fairness to Contact Lens Consumers Act
- S. 2777:
  - Requires contact lens sellers to verify prescriptions from physicians via communication method of their choice (phone, fax, email)
  - Requires contact lens sellers to set up dedicated live phone lines and email accounts to deal with inaccurate prescriptions
  - Prohibits sellers from advertising that expired prescriptions may be filled
  - Increases fines for false claims by sellers
Additional Priorities

- Medicare Patient Empowerment Act (H.R. 1650/S. 1849): Allows docs and patients to contract privately on a case-by-case basis without opting out of Medicare;

- Independent Payment Advisory Board (IPAB) Repeal: H.R. 1190 passed the House in July, included in reconciliation bill awaiting Senate action;

- Drug Compounding: Ophthalmic community advocating for changes to FDA draft guidance; beyond use date requirement too short for Avastin;

- Health insurer mergers: Medical community concerned about narrowing networks and mergers; under anti-trust review at Dept. of Justice.
2016 Medicare Physician Fee Schedule Final Rule

- **2016 Conversion Factor** = $35.8279
  - Achieving a Better Life Experience (ABLE) Act of 2014 established a 1% target for adjustments to misvalued codes for 2016, and required that payments under the fee schedule must be reduced by the difference between the target for the year and the estimated net reduction in expenditures. In CY 2016, the net reduction in expenditures resulting from adjustments to relative values of misvalued codes is 0.23%.
  - New conversion factor reflects the budget neutrality adjustment of -0.02%, the 0.5% update factor – MACRA, and the 0.77% target recapture amount.

- **Office-Based Cataract Surgery**: CMS requested feedback on office-based surgical suite cataract surgery in the proposed rule. ASCRS conducted a membership survey. Our comments suggested that while office-based cataract surgery would allow greater flexibility for scheduling and location, there are safety concerns that need to be considered. CMS noted they will take comments into consideration before making a proposal in a future proposed rule.

- **PQRS**: CMS did not make any major changes to reporting via claims or registry. CMS added a new Diabetic Retinopathy Measures Group.
2016 Medicare Physician Fee Schedule Final Rule

- **VBPM**: CMS will continue to apply the VBPM to all physicians in 2016.

- **Misvalued Codes**: Included in the 2016 misvalued services for review are: 92136 Ophthalmic Biometry, 92240 Icg Angiography, 92250 Eye Exam with Photos, and 92275 Electroretinography. CMS removed 92002 Eye Exam New Patient from the list in the final rule.

- Glaucoma and retina codes were reduced significantly more than the RUC recommendation. ASCRS is working with other ophthalmic specialty groups to advocate that these code reductions failed to take intensity into consideration and thus the reductions to the codes were too severe.
In the 2016 Medicare Physician Fee Schedule (MPFS) final rule, the cataract code 66984 reimbursement decreased 1% from $650.40 to $642.39 as a result of changes to the practice expense RVU. ASCRS realized that CMS had erroneously reduced the indirect practice expense for this code and notified CMS of this error. After discussions with CMS, they agreed to redo the calculations.

The update to the MPFS published in January 2016 included this correction to 66984.

In the original 2016 final rule, the cataract code 66984 practice expense RVU was 8.80, which resulted in the reduction to 66984. In the recent update, CMS increased the practice expense RVU to 8.98. In the original final rule, the total RVU was 17.91 for 66984. As a result of the practice expense change, the total RVU has increased to 18.11.
PQRS 2016

• 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 2016 Continued
For Ophthalmology

To successfully report for 2016, PQRS providers have a choice of reporting EITHER

1. The Cataract Measures Group or Diabetic Retinopathy 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 a Measure Group, you must report via registry for 20 patients, 50% (or 11) of which must be Medicare Part B patients.
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 2018 based on 2016 PQRS reporting.
- Group practices or solo practitioners who do not successfully report for PQRS in 2016 will receive an additional VBPM (penalty) of 2-4% depending on group size.
VBPM continued

- 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 2016, all groups and solo providers are now subject to quality tiering.
VBM 2016

• 10 or More Eligible Professionals
  – 4% penalty in 2018 for all groups of 10 or more eligible professionals that do not successfully report for PQRS in 2016
  – Quality Tiering
    • Maximum upward or downward adjustment +/- 4 times adjustment factor
    • -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 CY2016 based on the aggregate amount of downward payment adjustments
VBM 2016

• 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 2016
  – Quality Tiering
    • The maximum upward adjustment for groups of 2 or more EPs or solo practitioners is +2 times the adjustment factor.
    • These groups will be subject to negative adjustments under quality tiering in 2018.
CMS recently published results from the 2016 Value Modifier (based on 2014 reporting).

- The upward payment adjustment factor in 2016 is +15.92 percent.
- There are 13,813 physician group practices (with ten or more eligible professionals) that were subject to the 2016 Value Modifier based on 2014 performance.
- Physicians in 5,418 groups failed to meet minimum PQRS reporting requirements and will see a total of a -4 percent decrease in their Medicare payments in 2016 (2% - PQRS and 2% VBPM).
- 8,395 groups met the criteria to avoid the 2016 VBPM adjustment based on PQRS reporting and their 2016 Value Modifier was calculated using the quality-tiering methodology.
  - Of those groups, physicians in 128 groups will receive an increase.
  - 59 physician groups will see a decrease of either -1 or -2 percent in their Medicare payments.
  - Medicare payments for 8,208 physician groups will remain unchanged because they either had average cost and quality scores in 2014 performance or there was insufficient data to calculate the groups’ Value Modifier.
VBPM Results

• In some cases, providers may be attributed costs of care they did not provide based on the VBPM cost measure attribution process.

• Physicians can find information about their quality and cost performance in their 2014 Annual Quality Resource Use Report.

• Medicare Administrative Contractors (MACs) will begin paying claims based on the updated payment amounts after March 14, 2016.
  – CMS will reprocess CY 2016 claims with dates of service that were prior to this date.
CMS finalized the Meaningful Use Modifications and Stage 3 Meaningful Use final rule in 2015.

- The flexibility rule contains major changes to both Stage 1 and Stage 2 Meaningful Use for 2015-2017.

When first proposed, the Modifications to Stage 1 and 2 and Stage 3 were separate rules.

- ASCRS•ASOA advocated for the immediate release of the modifications rule and for a delay of the Stage 3 Meaningful Use final rule.
Meaningful Use
Flexibility Rule and Stage 3 Rule

- For 2015, providers had the option to report for any continuous 90-day period up to a reporting period of 365 days in a calendar year.
- For 2016 and 2017, all providers must attest for a full year.
- For 2016 and 2017, new participants in EHR reporting program can attest for any continuous 90-day reporting period.
Meaningful Use
Flexibility Rule and Stage 3 Rule

• Patient Engagement Measure Changes
  – For 2015 and 2016, CMS changed the 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.
  – For 2015, CMS changed the Stage 2 Secure Electronic Access measure from being a percentage based measure to a yes-no measure stating ‘functionality fully enabled.’ For 2016, 1 patient seen by the EP must be sent a secure electronic message.
CMS consolidated the public health measures into one objective in this rule. Providers are now required to actively engage with an immunization agency, a public health agency, or a clinical data registry—or qualify for exclusions for each measure to successfully attest to Meaningful Use.

After advocacy from ASCRS, CMS recently announced clarifications to the public health objective that should allow ophthalmologists to successfully meet the public health measures in 2016 through Frequently Asked Questions (FAQs).

The new guidance allows providers to claim an exclusion for public health objective measures if they were not previously intending to report a public health measure and either do not have the necessary software a registry requires or face a significant cost to connect to the interface.

In addition, CMS does not intend to penalize providers for changes to their systems or reporting made necessary by the 2015 EHR Modifications Rule. Specifically, the FAQ released clarifies that CMS will allow alternate exclusions for the syndromic surveillance and specialized registry measures in 2016.
Meaningful Use
Flexibility Rule and Stage 3 Rule

- **Hardship Exemption**: ASCRS was concerned with the lack of a specific hardship exemption in the rule due to the delay in the rule’s release.

- ASCRS contacted CMS for clarification, and CMS released the following FAQ:
  - A: ...However, if a provider is still unable to meet the requirements of meaningful use for an EHR reporting period in 2015 for reasons related to the timing of the publication of the final rule, a provider may apply for a hardship exception under the “extreme and uncontrollable” circumstances category. Each hardship exception application will be reviewed on a case-by-case basis, as required by law.
  - Hardship exemption applications for CY 2015 are due by July 1, 2016.
  - All providers can apply for the hardship exemption in 2015 under 2.2d, Vendor Issues, and cite that they are applying for the hardship exemption due to the delay in the release of the Stage 2 Modifications Rule.
CMS eliminated the distinction between menu and core measures and is requiring 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.
Physician Compare

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

• The Open Payments review and dispute period for 2015 payment data is currently open through May 15, 2016.

• Providers have 45 days (which began on April 1, 2016) to review and dispute information submitted by drug and device manufacturers on payments or transfers of value of greater than $10 made to providers.

• After the conclusion of the review and dispute period on May 15, CMS will publish the 2015 payment data and updates to the 2013 and 2014 data on June 30, 2016.

• Providers can review the data through the CMS portal.
Part B Drug Payment Proposal

- CMS released the Part B Drug Payment Model proposed rule, which proposes to test a new Part B drug payment model through the CMS Innovation Center. The proposed model would run for five years, beginning in the fall of 2016, and would consist of two phases.

- Today, Medicare Part B generally pays physicians and hospital outpatient departments the average sales price (ASP) of a drug plus a 6 percent add-on. The first phase of the proposed model would test whether changing the add-on to 2.5 percent plus a flat fee payment of $16.80 per drug per day changes prescribing incentives and leads to improved quality and value.

- Phase two of the model would implement value-based purchasing tools for Part B drugs using value-based pricing and clinical decision support tools. Proposals under phase two of the model include:
  - Discounting or eliminating patient cost sharing
  - Feedback on prescribing patterns and online decision support tools
  - Indications based pricing
  - Reference pricing to test the practice of setting a standard payment rate or benchmark for a group of therapeutically similar drugs
  - Risk-sharing agreements based on outcomes that would allow CMS to enter into voluntary agreements with drug manufacturers to link patient outcomes with price adjustments
Going Forward

• Continue to provide input into rulemaking for the new Quality Payment Program and advocate for changes to the newly enacted law as needed.

• Continue to advocate for CMS to accept the original RUC recommendations regarding Medicare reimbursement for the Glaucoma and Retina codes

• Monitor health plan mergers

• Cleaning and Sterilization of Ocular Surgical Instruments

• Continue to work with relevant stakeholders to ensure continued access to compounded and repackaged drugs.
What Can You Do?

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.

• ascrsgrassroots.org.
What Can you Do?

- Donate to eyePAC – ASCRS’ political action committee
- The collective voice of ophthalmology.
- eyePAC supports candidates who support our issues and serve on key committees with targeted donations.
- Hosts events in Washington, D.C. and supports member events back home.
- ASCRS members present eyePAC checks to candidates.
- Annual reception for donors at the ASCRS•ASOA Symposium and Congress

Donate online at: www.ascrs.org/eyePAC
Monthly donation option available.
Thank you!

Questions?

nmccann@ascrs.org