On October 13, CMS announced a new initiative to improve the clinician experience with the Medicare program. As we implement delivery system reforms from the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), this new long-term effort aims to reshape the physician experience by reviewing regulations and policies to minimize administrative tasks and seek other input to improve clinician satisfaction. The initiative will be led by senior physicians within CMS who will report to the Office of the Administrator.

The first action is the launch of an 18-month pilot program to reduce medical review for certain physicians while continuing to protect program integrity. Under the program, providers practicing within specified Advanced Alternative Payment Models (APMs) will be relieved of some scrutiny under certain medical review programs.
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The Centers for Medicare & Medicaid Services (CMS) has announced the Comprehensive Primary Care (CPC) initiative’s second round of shared savings results, with nearly all practices (95 percent) meeting quality of care requirements and four out of seven regions sharing in savings with CMS. These results reflect the work of 481 practices that served over 376,000 Medicare beneficiaries and more than 2.7 million patients overall in 2015.

As the largest test of advanced primary care in U.S. history, CPC demonstrates the potential of primary care clinicians redesigning their practices to deliver better care to their patients, and provides clinicians support to innovate and deliver care in ways that better meet their patients’ needs and preferences.

During 2015, its second shared savings performance year, CPC generated a total of $57.7 million gross savings in Part A and Part B expenditures. These savings are essentially equivalent to the $58 million paid in care management fees to the practices. Four of the seven regions participating in CPC – the states of Arkansas, Colorado, and Oregon, and the Greater Tulsa region in Oklahoma – realized net savings (after accounting for the care management fees paid) and will share in those savings with CMS.

Although three of the CPC regions had net losses, the savings generated in the other four regions covered those losses, such that care management fees across CPC were offset by reduced spending on Medicare Part A and Part B services. Further, more than half of participating CPC practices will receive a share of over $13 million in earned shared savings.

In addition to the gross Medicare savings, CPC practices showed positive quality, with lower than expected hospital admission and readmission rates, and favorable performance on patient experience measures. CPC practices’ performance on electronic Clinical Quality Measures (eCQMs) also exceeded...
national benchmarks, particularly on preventive health measures.

This is the first year CMS has included eCQM performance in Medicare shared savings determinations for CPC. eCQM reporting covering the entire practice population at the practice site level is critical to using health information technology as a tool to support care delivery transformation. eCQM data are recorded in the electronic health record in the routine course of clinical care, allowing practices to engage in real time quality improvement efforts that drive population health. As we move to a health care system that rewards value over volume, CPC practices are at the forefront of using eCQMs for quality improvement, measurement, and reporting.

QUALITY HIGHLIGHTS FROM THE 2015 SHARED SAVINGS PERFORMANCE YEAR INCLUDE:

• 97 percent of CPC practices successfully reported 9 eCQMs. For ten out of the eleven eCQMs in the CPC measure set, the majority of CPC practices who reported surpassed the median national performance.

• Nearly all (99 percent) practices reported higher levels of colorectal cancer screening and influenza immunization compared to national benchmarks. Additionally, 100 percent of practices who reported on screening for clinical depression surpassed national benchmarks.

• Compared to 2014, most regions maintained or improved their scores on hospital readmissions and admissions for chronic obstructive pulmonary disorder and congestive heart failure.

• Patients rated the care they receive from their CPC practitioners highly, particularly on how well practitioners supported them in taking care of their own health and the attention they paid to care from other providers.

The positive performance is a testament to the efforts CPC practices have made to provide truly “comprehensive primary care.”

CPC is a multi-payer partnership launched by the Center for Medicare and Medicaid Innovation (Innovation Center) in October 2012 to advance primary care by paying clinicians to deliver accessible, comprehensive, and coordinated care in seven regions across the country. CPC supports advanced primary care as the foundation of our health system. In addition to attending to patients’ acute, chronic, and preventive health care needs, primary care practices act as the quarterback of each patient’s health care team. CPC practices help patients navigate their care, communicate with specialists and hospitals, and ensure that patients with complex social and medical needs do not “fall through the cracks” of the health care system.

These results build on the first shared savings performance year in 2014. Gross savings nearly doubled from the first performance year to the second and practices in four regions were eligible to receive shared savings, compared to one region in 2014. Primary care transformation takes time, and it is especially encouraging that CPC practices maintained such positive quality of care results while also seeing gross Medicare savings in the 2015 performance year.

The experience in CPC has contributed to our continued efforts to support primary care going forward in the Innovation Center’s Comprehensive Primary Care Plus (CPC+), which will begin on January 1, 2017 and for which we recently announced the 14 selected regions and are currently reviewing practice applications. CMS anticipates that CPC+ could meet the criteria to qualify as an Advanced Alternative Payment Model (Advanced APM) under the recently finalized Quality Payment Program rule, which implements the Medicare Access and CHIP Reauthorization Act of 2015. A robust primary care system is essential to achieve better care, smarter spending, and healthier people. For this reason, CMS is committed to supporting primary care clinicians to deliver the best, most comprehensive primary care possible for their patients.
NEW MEDICATION MANAGEMENT PILOT LAUNCHES IN JANUARY

To better align prescription drug plan and government financial interests and create incentives for investment and innovation, CMS has chosen six organizations—including CVS Health, UnitedHealth and Humana—to participate in a new Part D enhanced medication therapy management model. Drug plan beneficiaries can opt out of the enhanced therapy management services at any time but stand to benefit because the price or number of medications they are on could be lowered. The five-year model begins January 1, 2017 in selected regions of Virginia, Florida, Louisiana, Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming and Arizona.
On October 16, Section 1557 of the Affordable Care Act goes into effect. This section is designed to provide meaningful access to individuals with Limited English Proficiency (LEP) among other things. Those affected by the provisions include all physicians receiving financial assistance from HHS (except solely Medicare Part B). According to the final rule, rural health clinics are considered covered entities and will need to comply with the provisions.

In general, RHCs must post taglines and notices concerning the availability of language assistance for non-English speaking individuals. A tagline is a “short statement written in non-English informing individuals that language assistance services are available free of charge.” The taglines must be posted in the 15 most spoken languages in each state; a list of most spoken languages was published by CMS.

Section 1557 is intended to prevent any health programs that receive federal money from discriminating on the basis of race, color, national origin, sex, age, or disability. The rules require no-cost language assistance for individuals with LEP. The rules also specify how written and oral communication must be interpreted; stating that a “qualified translator” must be used when translating written content and oral interpretation must be provided when it is a reasonable step to provide meaningful access. Section 1557 also requires that if the covered entity has 15 or more employees, there must be an employee designated to handle 1557 compliance and grievance procedures.

Besides its protections for individuals with LEP, the section also: extends protections against sex discrimination, incorporates laws that aim to prevent disability-based discrimination, and prohibits discriminatory health insurance benefit designs.

HHS has provided the following resources to assist with compliance:
- Sample notices and taglines
- Training slides
- Training guide
- Estimates of language spoken
The Office of the National Coordinator for Health IT has finalized a rule that will give it more oversight over certifying electronic health records and other technologies that store, share and analyze health information for consumers. The rule also gives the ONC the authority to ask developers to pull noncompliant products from the market.

The ONC first proposed increasing its role in the certification, review, and testing of health IT products in a draft rule released this past March. The agency received 48 comments by its May 2 deadline.

The ONC would now have the power to decertify health IT products that don’t comply with regulations or are found to pose a risk to public health or safety, for example, if they caused medical errors.

If the ONC decertified a product, its developer would be required to notify affected customers and providers who purchased the products. The ONC would also issue a cease-and-desist notice to prevent the future sale or marketing of the product.

In the final rule, the agency backed off a proposal to review cases in which nonconformity could compromise the security or protection of patients’ health information or that could lead to inaccurate or incomplete documentation and result in bad or duplicative care.

“Our decision not to establish regulatory processes for such oversight at this time is based in part on the recognition that other agencies have the ability to investigate and respond to these types of issues and our desire to make the most efficient use of limited federal resources,” the rule said.

Response to the rulemaking was mixed. The American Medical Association supported the ONC’s idea to use corrective actions to resolve patient safety and security issues involving an IT product. However, the trade group was concerned about the suspension or termination of an IT product’s certification.

That action “may have serious repercussions for physicians and patients. Without these tools, physicians and patients may be unable to access necessary information or coordinate care,” the trade group said in a letter commenting on the draft rule.

In response to the comment, the agency emphasized termination is a last resort. It also added a new, intermediate step in the direct review process called “proposed termination.” That will give health IT developers a chance to resolve issues regarding a nonconformity prior to decertification.

The College of Healthcare Information Management Executives, a trade group that represents chief information officers at hospitals, praised the rule for addressing clinicians’ concern about the usability of EHRs. Other members worry that some systems fail to calculate quality measurement data correctly, jeopardizing the accuracy of information that is increasingly tied to payment and penalties for providers.

The Electronic Health Record (EHR) Association felt the ONC’s proposed rule inappropriately expands the agency’s legal authority.

The potential costs of this rule for health IT developers, the ONC and healthcare providers may be as much as $650 million, with an annual cost of $6.5 million.
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NARHC SUPPLIES FREQUENTLY ASKED QUESTIONS REGARDING RHCS AND MIPS

Q: Will my RHC All-Inclusive Rate be affected by the new Medicare Incentive Payment system (MIPS)?

A: No. The final rule states that because RHC services furnished by eligible clinicians (Physician, PAs and NPs) are not reimbursed under the Medicare PFS (Physician Fee Schedule), RHC services are not covered by the MIPS program. Reimbursement for RHC UB-04 claims will be unaffected by this new program. The RHC Cap will continue to adjust each year to reflect medical inflation and productivity improvements.

However, non-RHC claims submitted by RHC Physicians, PAs and NPs to Medicare Part B (i.e. items billed on a 1500-form) may be affected (see below).

Q: Will non-RHC services (billed on a 1500) using the individual/group NPI be affected by MACRA?

A: Potentially. We believe MOST RHC physicians, PAs and NPs will fall under a low-volume exemption threshold (see below), which will exempt these clinicians and their 1500 claims from MIPS reporting and payment adjustments.

Q: What is the low-volume threshold?

A: CMS has determined that Physicians, PAs and NPs who do not submit sufficient Medicare Physician Fee Schedule (1500) claims will be exempt from the MIPS program. These are classified as “low-volume” providers. A low-volume provider is defined as a Physician, PA or NP who, during the low-volume threshold period,

1. has billed Medicare Part B allowed charges of $30,000 or less during the billing cycle; OR
2. provided care to 100 or fewer Medicare Part B-enrolled beneficiaries during the billing cycle.

RHC claims are NOT counted when determining whether or not a clinician meets the threshold.

Q: What billing cycle will CMS use to do the claim or patient count?

CMS will review Physician, PA and NP Medicare Physician Fee Schedule billing for the 24 months preceding the reporting year broken into two, separate 12 month calculations or “billing years”. These will not be calendar years but rather so-called “billing year”. For 2017 (2019 payment adjustment year), the “billing year” reviewed by Medicare will be claims submitted between September 1, 2015 through August 31, 2016. CMS will conduct a second “billing year” calculation based on claims submitted between September 1, 2016 through August 31, 2017.
to determine additional eligible clinicians and groups.

If the individual Physician, PA or NP claim submissions are $30,000 or less during EITHER of these billing years, the clinician will be considered exempt from MIPS for the associated Payment Adjustment Year. Each year after 2017, CMS will conduct a similar review with the older year dropping from the calculation and the most recent September – August “billing year” being added to the calculation. Again, as long as the Physician, PA or NP meet the low volume criteria during either of the two years, the clinician would be deemed MIPS exempt.

CMS will also use this same 24 month review method to do the patient count.

Q: How will Medicare know if an individual clinician provides care to fewer than 100 Part B-enrolled Medicare beneficiaries?

A: CMS will use social security numbers reported on 1500 claims to determine this part of the exclusion. This is a count of patients, not claims. For example, if an eligible clinician provides multiple services to one RHC beneficiary over the course of the “billing year”, this only counts as one Medicare enrolled beneficiary for purposes of the low-volume threshold.

Q: Will Clinicians have to apply for the low-volume exemption?

A: No. CMS says it set up the low-volume threshold determination period in such a way that will allow CMS to notify Physicians, PAs and NPs who qualify for the exemption during the month of December preceding the quality reporting year. CMS has not specified how notification will occur. We expect that CMS will issue guidance on this within the next few weeks.

Q: How is CMS identifying individuals versus groups for the purposes of the low-volume exclusion?

A: For individuals, the low volume threshold is determined by the Tax ID Number (TIN)/National Provider Identifier (NPI) combination. For groups, low volume exclusions are determined by simply the TIN. Individual eligible clinicians that are part of a group that chooses to report as a group, will be required to participate in MIPS if the entire group qualifies.

For example, if five RHC eligible clinicians are a part of the same group (TIN) and each eligible clinician bills $10,000 of allowable Medicare Part B charges, then that group has the option to report as a group and be subject to MIPS as a group (meaning they all get one group quality score) or to report as individual eligible clinicians and take the low-volume exemption.

In this example, if they report as a group with total Medicare allowable charges of $50,000, then their Part B claims are going to be required to report MIPS quality data to CMS and have their Part B (1500) claims subject to MIPS adjustments (positive or negative). However, if the clinicians report individually, $10,000 per, then all five would be exempt from quality reporting and exempt from MIPS adjustments (positive or negative) on their Medicare Part B claims.

Q: If an eligible clinician qualifies for the low-volume exclusion, can they choose to opt-in to MIPS and receive an adjustment?

A: No. Once it has been determined that for the reporting year a clinician or group is deemed “low-volume”, the clinician or group is ineligible to participate in MIPS for that reporting year.

Q: Can Rural Health Clinics voluntarily report MIPS data?

A: Yes RHCs may voluntarily report MIPS data and receive a MIPS CPS score. However, any MIPS data reported on RHC services would not be used for the purposes of the MIPS payment adjustment on non-RHC claims.

At some point Congress may propose to extend the MIPS program to RHCs and it would be helpful to know how RHCs would fair under the
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