**Pre-election update**

**Several issues will be impacted by upcoming elections**

With national and state elections just around the corner, here’s an overview of what you need to know.

**State of the state**

The General Assembly kicks off its 2017 session on Jan. 11. As we’ve been tracking over the summer, Medical Society of Virginia’s proposed legislative agenda appears to focus primarily on the practice of medicine. Its three leading priority issues relate to scope of practice and licensure legislation for associated physicians, prescription misuse and taking a “wait and see” posture on Certificate of Public Need (COPN) regulation changes.

As a collaborative partner with MSV, the Virginia Medical Group Management Association (VMGMA) Board this summer determined that we should try to influence legislation focused on the business of medicine. To that end, we need to know our members’ positions on potential legislative items of interest.

The Legislative Committee is currently formatting a survey to seek your feedback on a number of topics, including COPN repeal and reform, direct primary care agreements and prior authorizations. Watch your email in the coming weeks for a link to the survey.

Nov. 8 is Election Day, with only a handful of contested races this year in the General Assembly. On the ballot across Virginia, however, is an amendment referendum to add “right to work” language into Article I of the state constitution.

If approved (a vote “FOR” the measure), the amendment would strengthen the existing statute, making it illegal for workplaces to require mandatory labor union membership for employees as a condition for employment. The change would memorialize the existing state statute into the constitution, strengthening its enforcement and making it more difficult to be overturned by future administrations.

**State of the union**

Nov. 8 is also Election Day at the national level. The Kaiser Family Foundation will track several issues that will be impacted by upcoming elections.
The Virginia Medical Group Management Association Board was excited to offer yet another outstanding educational opportunity at the lovely Kingsmill Resort in Williamsburg.

This conference offered a breakout on workplace violence and a reception on Sunday evening. More breakouts were held on Monday as was our VMGMA Olympics, which included a life-sized Jenga game, puzzles, relay races and more. VMGMA’s gold medal winner was Spain, silver went to Poland and bronze was awarded to the USA.

On Tuesday, we had a panel discussion on the opioid laws and a general session on mastering patient flow. All offerings were well-attended and well-received. VMGMA continues to offer educational credits at each conference for ACMPE and AAPC. Please make sure to utilize this valuable benefit.

Feedback was very positive. Participants overwhelmingly rated our most recent conference with high marks. Here are some of the survey results:

Did you feel this educational event was a good value for your practice? 96% of respondents answered "yes."

Did this educational event address your current educational needs? 94% of respondents answered "yes."

Speakers at the conference included Joe Rosner, Monica Wofford, Holly Van Auken, Peter Verlezza, Pamela Ballou-Nelson, Jonathan Sumrell, Elizabeth Woodcock, Nancy Rose-Senich, Jerry Canaan, Ralph Orr, Dr. Karla Walker and Joseph Gierok.

Attendees rated our speakers with an average weighted score of 4.26 out of a possible 5.

Our goal for attendees was that these sessions would encourage critical thinking and address marketplace pressures, reimbursement issues, compliance challenges and decision-making processes for your practice.

VMGMA believes each attendee deserves an education tailored to individual strengths and needs. Therefore, we will continue to present sessions based on your requested content areas.

The years of experience of those attending the conference varied greatly. This always presents a challenge to the Education Committee, ensuring that all members have the ability to attend breakouts based on their individual needs and level of experience. Therefore, at our Spring Conference we will begin to label the individual sessions as follows:

Basic – Designed to provide a general understanding of a topic or knowledge area.

Intermediate – Designed to develop a working knowledge of a topic or knowledge area, or build on a basic curriculum.

Advanced – Designed to develop in-depth expertise on a topic or knowledge area.

Attend the Spring Conference

Don’t miss the Spring Conference in Charlottesville, where VMGMA will be offering a new format called Master Series. This is designed to allow participants a more in-depth look into the various offerings.

We hope to see you at Boar’s Head Inn in Charlottesville for the Spring Conference, March 19-21.

The author of this article, Patricia J. Mullins, FACMPE, is an Administrator at Infectious Disease Physicians in Annandale. Her phone number is (703) 560-7900, and her email is tmullins@idphysicians.net.

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Stop for a moment and consider the responsibility you have as a professional medical manager.

Every day you manage employees (Human Resource Management); you maintain the strategic direction of your medical group and keep your physicians moving forward (Governance); you maintain the flow of the office and deal with outside vendors (Business Management); you make sure technology is in working order and up to date (Information Management); you oversee the safety of your patients (Patient Care Systems); you maintain regulatory requirements, such as OSHA and corporate compliance (Risk Management); you make sure your practice is reporting data necessary to demonstrate quality measures (Quality Management); and finally, you analyze and benchmark financial data and report to your physicians on the financial position of your practice (Financial Management).

By merely doing your job every day, you are working with the Body of Knowledge from the Medical Group Management Association.

Get credit for your industry knowledge

Why not put your knowledge and expertise to the test—literally? Certification is something that each of you can achieve! There are three simple steps:

1. Join MGMA-ACMPE.
2. Pass a 175-question objective examination and a 3-question essay examination, given at nearby testing sites. The next exams will be given December 3–17, and registration is open through November 2.
3. Accumulate 50 hours of CEUs (continuing education units). You can gain these by: attending the MGMA-National Conference in San Francisco, the VMGMA semiannual conferences and local VMGMA meetings; participating in online study groups and educational webinars; and reading articles in the MGMA Connexion magazine or completing other online assessments through ACMPE.

How much exam preparation is too much? Practice is one of the most effective methods of preparing for the certification exams. However, don’t get caught up in a never-ending cycle. If you have already practiced with 200 or more objective questions and/or five or more essays, you are more than ready. Remember, the exams are based on what you do every day as a successful practice management professional, and spending too much time practicing can keep you from attaining your goal: taking and passing the exams!

If you haven’t started preparing yet, consider the following:

- Practice for the objective exam by taking the free Body of Knowledge Quiz, available on the national MGMA site. Your quiz score can be used as an indication of how you might perform on the actual exam, which requires that you have a correct score of at least 70% to pass.
- Sample essay questions are also available for practice. Since there can be several correct answers, ask an ACMPE Fellow to give feedback on your approach.
- The Certification Exam Workbook, also available on the national MGMA site, provides samples of successful essays from past exams in addition to rationale for correct answers to objective questions.

Next career step is fellowship

Fellowship is the next career challenge and is the highest level of distinction you can earn in the medical practice management profession. Join others who are dedicated to making a difference and creating best practices in the health care industry. This requires writing a professional paper on a relevant health care topic.

If you are interested in a study group, please see the VMGMA website, where in the Member’s Only section you’ll find a link to "ACMPE," or contact me and I will assist you in finding a group.

Members who recently earned certification

Please join me in recognizing and congratulating those from our state who have achieved certification in 2016: Tracey S. Quance, Jonathan S. Semple, Renita Buckner, Narwan Gobair, Amy Miller Allen and Karen Knichel.

The author of this article, Patricia J. Mullins, FACMPE, is an Administrator at Infectious Disease Physicians in Annandale. Her phone number is (703) 560-7900, and her email is tmullins@id-physicians.net.

Sample ACMPE essay questions

1. You are the administrator for a medical practice that is a for-profit corporation. You have noticed physician turnover due to fluctuating incomes, a dependence on financing 100 percent of capital purchases and a need to rapidly recruit a number of new physicians.

   Describe how you would handle this situation and discuss the rationale for your course of action.

2. You are the administrator of a five-physician medical practice. Your board of directors has decided to double the number of providers within the practice. At its next meeting, the board would like you to propose a plan of action to accomplish this goal.

   Describe how you would develop this plan of action and discuss the plan’s critical components.

3. You are the administrator of a medical group. The nursing director approaches you for advice on how best to respond to a complaint from a nurse about a verbally abusive patient. This nurse refuses to care for the patient because he uses language that she finds vulgar and offensive.

   Discuss how you would handle this situation.

4. You are the administrator of a medical group practice. One of your physicians approaches you, upset that he had six no-show appointments that day. He complains that this is an ongoing problem. He asks you to research and correct this problem immediately.

   Describe your plan of action.

Sample ACMPE essay questions are available for practice and can be downloaded from the MGMA website.
Electronic communications: Tips for your practice

by Anisa P. Kelley, Esq. and Rachel L. Procopio, Esq.
from RawlsMcNelis

Over the past decade, as the use of smartphones has become prevalent, instant access to email and text messaging has become common. This new accessibility and the ability to connect instantly have not been lost on health care providers and their patients. In fact, many health care providers have come to rely on the availability of instant communications to enhance their medical practices. Smartphone access has allowed providers to communicate with patients and other health care providers using emails and text messages, which offer instant feedback. Despite the convenience for both providers and patients, these communications may create serious issues for covered entities when considering the Healthcare Insurance Portability and Accountability Act (HIPAA).

HIPAA was signed into law by President Bill Clinton on Aug. 21, 1996. The original objectives of the act included: improving the portability and accountability of health insurance coverage when employees changed jobs; bringing individual privacy rights to patients; requiring that providers notify patients of their rights; and eliminating fraud, waste and abuse in health care. In 2003, the Department of Health and Human Services (HHS) issued and adopted the HIPAA Privacy, Security and Enforcement Rules, which gave individuals rights regarding their protected health information (PHI), set national privacy standards for protecting this information and addressed covered entities’ compliance with these rules.

HIPAA has evolved with changing technology. In 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted. It addressed the changing health information landscape as covered entities transitioned from paper-based medical records to electronic health records (EHR). It also addressed the electronic transmission of PHI and the security concerns associated with this type of transmission. HHS issued the HIPAA Omnibus Rule in 2013. This rule made some final modifications to existing legislation, including the Privacy, Security and Breach Notification Rules. Arguably the most significant change was that the Omnibus Rule made business associates of covered entities directly liable for compliance with certain privacy and security requirements.

HIPAA encompasses a broad range of topics related to health care and creates a number of requirements associated with its current Privacy, Security and Breach Notification Rules. This article focuses on the interplay between HIPAA requirements and the use of emails and text messages.

HIPAA requirements for emails and text messages

HIPAA allows providers to communicate electronically with their patients and permits the transmission of PHI by electronic means. However, HIPAA requires that safeguards be put in place to ensure that PHI is not inadvertently disclosed to improper parties. Both the Privacy and Security Rules are implicated when considering dissemination of PHI by electronic means. Each of these rules creates separate requirements that must be met to ensure HIPAA compliance by a covered entity, like a health care provider. When examining a practice’s electronic communication policies and procedures, both the Security and Privacy Rules should be considered.

According to HHS, HIPAA’s Privacy Rule “allows covered health care providers to communicate electronically, such as through email, with their patients, provided they apply reasonable safeguards when doing so” [see 45 C.F.R. § 164.530(c)]. The Privacy Rule does not require that all treatment-related emails between patients and providers be encrypted. However, HHS recommends that other safeguards be applied to “reasonably protect privacy,” including limiting the amount or type of information disclosed in unencrypted emails. HHS provides some helpful guidelines when dealing with electronic transmission of PHI. It lists precautions that can be taken when using email to avoid unintentional disclosures of PHI, like “checking the email address for accuracy before sending,” or “sending an email alert to the patient for address confirmation prior to sending the message” that contains PHI.

Providers should also contemplate that patients may initiate communications with them using email. In that situation, unless the patient has explicitly stated otherwise, the health care provider can assume that email communications are acceptable to the individual patient. The health care provider can alert the patient of the potential risks of using unencrypted email if he or she believes the patient is not aware of the risks, or if the health care provider has concerns about potential liability. This warning would allow the patient to decide whether to continue email communications with the health care provider.

An additional consideration is HIPAA’s alternative communications provision. Under HIPAA’s Privacy Rule, a patient has the right to request that his or her health care provider communicate with the patient by alternative means or at alternative locations if these requests are deemed reasonable [see 45 C.F.R. § 164.522(b)]. Adherence to this rule may include honoring an individual’s request to receive appointment reminders via email or text message instead of in written correspondence, if this is a reasonable means for the specific health care provider. A patient who is concerned with privacy can request that more secure methods of communication are used instead of unencrypted email. A health care provider can seek out the individual’s preference by using a dedicated form. If a patient wishes to receive email communications instead of standard paper communications, it is important that the provider document this preference in writing.

A covered entity may not be responsible
if an unintended individual receives PHI. For example, HHS has advised that a covered entity is not responsible if it complies with an individual’s access request to receive PHI in an unsecured manner, such as through unencrypted email, and the information is intercepted while in transit. Covered entities are responsible for adopting reasonable safeguards in implementing the individual’s request, such as ensuring that the correct email address for the patient has been entered. Conversely, covered entities are not responsible for PHI disclosures during transmission to the individual, or a third party at the individual’s instruction, based on the individual’s access request to receive PHI in an unsecured manner. This, however, requires that the covered entity warn the individual of the risks associated with the unsecured transmission and that the patient accepts the associated risk. Further, covered entities are not responsible for safeguarding information once the information has been delivered to the individual.

In summary, covered entities are responsible for breach notification for unsecured transmissions and may be liable for impermissible disclosures of PHI occurring in all contexts except when the covered entity is fulfilling an individual’s right to receive his or her PHI in an unsecure manner.

In addition, HHS states that the HIPAA Security Rule’s standards for access control, integrity and transmission security require covered entities to implement policies and procedures to “restrict access to, protect the integrity of, and guard against unauthorized access to [electronic] PHI.” HHS provides additional tips for safeguarding the electronic transmission of PHI under both the Privacy and Security Rules.

HHS also provides that the standard for transmission security includes addressable specifications for integrity controls and encryption. This means that the covered entity must assess its use of open networks, identify the available and appropriate means to protect electronic PHI as it is transmitted, select a solution and document the decision. The Security Rule allows for electronic PHI to be sent through an open electronic network as long as it is adequately protected.

A key concept is that HIPAA’s Security Rule is considered “technology neutral,” meaning no one particular technology can deliver HIPAA compliance. Rather, the Security Rule requires implementation of a system of safeguards.

From a Security Rule perspective, covered entities must be particularly careful when physicians use their personal devices to transmit and receive patient data. These messages may not subject to an encryption mechanism put in place by the covered entity if the health care provider is using his or her personal device. Further, there is no way to confirm that the recipient has received the text message or to increase the priority of certain messages. These concerns are especially relevant as providers move away from using pagers toward communicating through emails and text messages.

**Penalties for violations**

The penalties — both civil monetary penalties and criminal penalties — for violating HIPAA are steep. HHS’s Office of Civil Rights, which is responsible for enforcing the Privacy and Security Rules, assesses penalties per violation. High financial penalties may be assessed if a covered entity has engaged in a noncompliant practice for a period of time. For larger organizations, a noncompliant practice would likely affect the PHI of many patients. The minimum penalty for each violation ranges from $100-$50,000; the maximum penalty assessed per covered entity is $1.5 million per calendar year for all violations of an identical HIPAA provision.

There are four tiers associated with civil monetary penalties for covered entities. Tier one includes violations that have occurred when the covered entity or individual did not know (and by exercising reasonable diligence would not have known) that the act violated HIPAA. Penalties for tier one violations are $100-$50,000 per each violation, up to a maximum penalty of $1.5 million for all violations of an identical provision during a calendar year.

Tier two violations include violations with reasonable causes that were not due to the covered entity’s willful neglect. Penalties for tier two violations are $1,000-$50,000 per violation and up to a maximum penalty of $1.5 million for all violations of an identical provision during a calendar year.

Tier three violations are due to willful neglect of the covered entity but the violation was corrected within the required time period. These violations are punishable with $10,000-$50,000 fines for each, up to a maximum penalty of $1.5 million for all violations of an identical provision during a calendar year.

Finally, tier four violations are due to willful neglect and were not corrected by the covered entity. The penalties are $50,000-$150,000 per violation and up to a maximum penalty of $1.5 million for all violations of an identical provision during a calendar year.
ELECTRONIC COMMUNICATIONS, continued from page 5

$50,000 or more for each violation, up to a maximum penalty of $1.5 million for all violations of an identical provision during a calendar year.

Criminal penalties are assessed based on three tiers: “unknowingly or with reasonable cause” can include a sentence of up to one year; “under false pretenses” allows for a sentence of up to five years; and “for personal gain or malicious reasons” allows for sentencing up to 10 years.

Tips for HIPAA compliance for emailing and texting

There are several ways to ensure that your covered entity complies with HIPAA in terms of transmission of electronic data. HealthIT.gov proposes a five-step plan for organizations to manage mobile devices used by health care providers. These include: deciding whether mobile devices will be used to access, receive, transmit or store patients’ PHI or as part of the organization’s system; assessing how mobile devices affect the risks to the organization’s health information; identifying the organization’s right to communicate with providers using their preferred means of communication, so long as the means are reasonable to the provider. As such, patients could ask for communication using text or email. If patients elect these types of communications and the covered entity does not employ a secure platform for them, the individual must be informed of the risks associated with these types of communications. Patients must also be advised of the risks of a data breach related to the insecure nature of the communication.

• Encrypt individual devices. Covered entities may encrypt provider’s electronic devices. This helps prevent unauthorized people from reading private PHI stored on a device.

• Use a secure messaging platform. Covered entities may also consider purchasing secure messaging platforms for providers to use when communicating among themselves or with patients. Some technology companies specialize in providing a secure texting platform to

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mobile device risk management strategy by analyzing privacy and security safeguards; developing, documenting and implementing mobile device policies and procedures; and training providers and professionals regarding mobile device privacy and security awareness. These steps provide some helpful guidance for covered entities.

To help avoid civil and criminal sanctions for HIPAA violations, a covered entity can take a number of steps with regard to electronic transmission of PHI:

• Develop practice rules and policies for emails and texting. Understand how to address HIPAA’s requirements. Create HIPAA-compliant policies and practices. Enact rules and develop policies regarding the use of emailing and text messaging of PHI, and implement these policies with proper training for all providers and staff members.

• Develop a patient understanding statement for those who want to use emails and texting. Pursuant to HIPAA’s patient access policies, patients have the

covered health care entities. These platforms provide encrypted messages that are sent across a secure server. Text messages are also stored using the platform’s secure servers rather than on the health care providers’ individual mobile devices. These companies allow providers to send text-like messages quickly and efficiently. The messaging platforms can allow providers to upload communications directly to an EHR as a PDF. One drawback to these types of platforms is that others must use the platform to communicate.

Keeping PHI protected in the age of emails and text messages is a significant concern for health care providers. Covered entities can take a variety of steps to allow providers to communicate with patients by email or text messaging while helping to ensure compliance with HIPAA and avoiding significant penalties. With proper policies and procedures to protect PHI, new technology will help, not hinder, the delivery of health care.

PRESIDENT’S MESSAGE, from page 1

and once in the summer at the Medical Society of Virginia office and then have our retreat in Richmond in November.

Most of the work is done through committees, over conference calls and in emails. The commitment is one that can easily be absorbed into an already-busy schedule.

Ever wonder just how those great conferences are planned? The Education Committee works over several phone meetings to plan the timely content. The Executive Committee also meets over the phone to support Jody, as issues arise.

I am hoping this short overview has given you enough to consider joining us in planning the activities of this great organization. At our upcoming Board Retreat, we are taking an in-depth look at how our board is currently organized. This may result in additional board members being needed. Here’s your chance to join this talented group of caring individuals and be part of greatness!

If you’re interested in joining the board, please contact the VMGMA office at vmgma@comcast.net or call 804-328-3344.

The author of this article, Chris Auville, FACMPE, is an Administrator with Harrisonburg Medical Associates in Harrisonburg. She can be reached by phone at (540) 820-4927 or by email at cauville@bmahealth.com.
has been tracking the health care positions of the two leading presidential candidates and offers this comparison on its website. Additional information can be found on all three of the candidates’ campaign sites:

- **Clinton**
- **Johnson** (Note that the Libertarian candidate does not have a specific health care platform published, so I linked an analysis provided by Forbes earlier this month.)
- **Trump**

In addition, all 11 Virginia House of Representatives seats are up for grabs this year. Check the VMGMA Legislative Page prior to the election for position statements on the candidates in your district.

### State of the future

The final MACRA ruling was released by CMS on the day this article went to the editor. I am currently reviewing the final details of the 2,398-page law and will summarize key sections on the VMGMA website in the near future. For now, here are some of the more meaningful changes from the proposed rule:

1) Mandatory reporting requirements were relaxed for 2017. If you’re ready, you can begin collecting your performance data on Jan. 1. If you’re not ready on Jan. 1, you can choose to start any time before Oct. 2. Performance data needs to be submitted by March 31, 2018. Your practice’s ability to benefit financially under MACRA in 2019 will scale, based on what you do. Here are the options:

- **Don’t participate:** If you don’t send in any 2017 data, you will receive a negative 4% payment adjustment.
- **Submit something:** If you opt to test the system and submit a minimum amount of 2017 data (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment.
- **Submit a partial year:** If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.
- **Submit a full year:** If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment (up to the 4% max.)

2) The MIPS scoring guidelines have changed. The final rule allocates weights to the reporting categories as shown in the table above.

3) CMS expanded the MIPS exclusion criteria for providers who treat a low volume of Medicare patients. Physician practices with less than $30,000 in Medicare charges or fewer than 100 unique Medicare patients per year will be exempted. This increase from the draft rule (originally $10,000/ year) is expected to significantly benefit small practices and rural providers. A recent American Medical Association analysis found that about 30% of all MIPS-eligible clinicians would be exempt under the new version of the rule.

4) The final regulations also answer requests for lower minimum reporting thresholds. The agency originally wanted providers to report quality measures on 90% of their patients from all payers and 80% of Medicare patients. Small providers argued they would have a harder time obtaining the information technology and data needed to meet that requirement. The final rule drops the Medicare threshold to 50%. The number of measures that must be reported in categories have been reduced, as indicated above.

5) CMS expanded the inclusion criteria for Alternative Payment Model participation. Under the final rule, physicians qualify as an APM if they are in an MSSP Track 2 or 3 ACO, Next Generation ACO Model or Comprehensive ESRD Care Model (Two-Sided Risk Arrangements). A final list, which may be expanded, will be published prior to Jan. 1. For the 2018 performance year, CMS anticipates that the following additional models would be considered APMs: ACO Track 1+, New Voluntary Bundled Payment Models and Advancing Cardiac Care Coordination through Episode Payment Models (Cardiac and Joint Care).

6) CMS said it would provide $100 million in technical assistance to clinicians participating in MIPS who are in small practices, rural areas and in areas with a shortage of health professionals.

If you would like to read ahead, an executive summary is available at CMS Quality Payment Program. Additional helpful information to get acquainted with the components of MIPS and APM can be found here:

- AAFP Medicare Payment Primer
- ACP Overview on MACRA

### MIPS scoring guidelines final rule, weights by reporting category

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<thead>
<tr>
<th>Category</th>
<th>2017 Weight</th>
<th>Requirements</th>
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<tbody>
<tr>
<td>Quality (replaces PQRS)</td>
<td>60%</td>
<td>Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days</td>
</tr>
<tr>
<td>Clinical Improvement Activities</td>
<td>15%</td>
<td>Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days</td>
</tr>
<tr>
<td>Advancing Care Information (replaces MU)</td>
<td>25%</td>
<td>Fulfill the required measures for a minimum of 90 days:</td>
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<td></td>
<td></td>
<td>• Security Risk Analysis</td>
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<td></td>
<td></td>
<td>• e-Prescribing</td>
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<td></td>
<td>• Provide Patient Access</td>
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<td>• Send Summary of Care</td>
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<td>• Request/Accept Summary of Care</td>
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<td>Choose to submit up to 9 measures for a minimum of 90 days for additional credit</td>
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<tr>
<td>Cost (replaces VBM)</td>
<td>0%</td>
<td>No data submission required, counted starting in 2018</td>
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Finally, CMS released its proposed 2017 Physician Fee Schedule a few weeks ago. The “losers” under the preliminary fee schedule are interventional radiologists, vascular surgeons and pathologists. The “winners” are family practice and internal medicine (and medical sub-specialties) due to a number of changes that can help strengthen primary care reimbursement and coverage for care coordination. Those changes are:

1) Two new codes to pay separately for non-face-to-face prolonged E/M services (before or after direct patient care). CMS currently considers these to be bundled unimportant.

**LEGISLATIVE UPDATE, continued on 8**
VMGMA salutes its 2016 corporate sponsors

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LEGISLATIVE UPDATE, from page 7

der existing CPT codes.

2) Three new G-codes for behavioral health integration services included in the Psychiatric Collaborative Care Model (CoCM). In CoCM, care is provided by a primary care team, which works in collaboration with a psychiatric consultant. It includes structured care management with regular assessments of clinical status.

3) CMS proposes some extensive changes to CCM, particularly the onerous billing requirements:

- Changes the requirement for an “initiating” face-to-face visit — instead of all beneficiaries, they propose just those patients who are new or who have not been seen within the past year. Others can be enrolled telephonically.
- Obtaining the beneficiary’s consent can now be documented directly in the medical record, rather than requiring a written agreement.
- Adds a payment for those “initiating” visits that involve care planning beyond the scope of CCM.
- Covers more complex and time-intensive CCM services with new CPT codes, which pay at higher rates.
- Removes the requirement that CCM practitioners must have after-hours access to the electronic care plan. Allows the after-hours provider to share urgent care information “on a timely basis” (which includes faxing) rather than mandating 24/7 access to the electronic care plan.

In addition, the CMS indicates advanced scrutiny of global surgery codes and provides further alignment with MACRA.

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