



Pay for Performance:

Live at a Physician Practice Near You!!!

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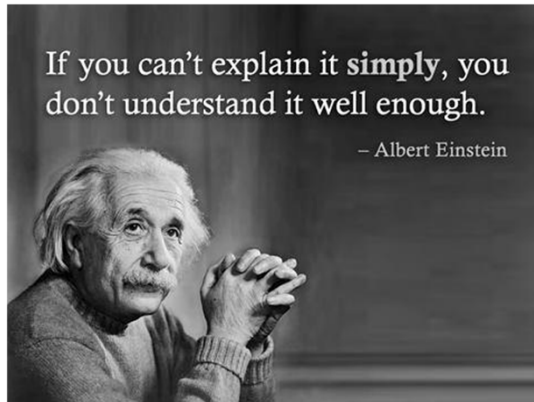
CMO

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MACRA 101

If you can't explain it **simply**, you
don't understand it well enough.

– Albert Einstein



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Agenda

- Why you need to know about MACRA
- What is MACRA?
- Who is eligible to participate
- Coding Considerations for MACRA
- Resources



The Impact

- Far Reaching
- Not Just Physicians
- Not Just Physician Practices
- Success will take a village:
 - Keys to Success
 - Documentation Improvement Teams
 - Coding Teams



Hospital-Based	MIPS eligible clinician who furnishes 75 percent or more of covered professional services in an inpatient hospital, on-campus outpatient hospital or emergency room setting in the year preceding the performance period
Non-Patient Facing	<ul style="list-style-type: none"> • Individual MIPS eligible clinician who bills 100 or fewer patient-facing encounters (including Medicare telehealth services) during the non-patient facing determination period. • A group where more than 75% of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician during the non-patient facing determination period.



42 CFR Parts 414 and 495 [CMS-5517-FC]

Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models



“Physicians and their care teams are the most vital resource a patient has. As we implement the Quality Payment Program under MACRA, we cannot do it without making a sustained, long-term commitment to take a holistic view on the demands on the physician and clinician workforce,” The new initiative will launch a nationwide effort to work with the clinician community to improve Medicare regulations, policies, and interaction points to address issues and to help get physicians back to the most important thing they do – taking care of patients.”

Andy Slavitt, acting Administrator of CMS



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What's New?

- MACRA (Medicare Access and Chip Reauthorization Act) repeals the Medicare Sustainable Growth Rate methodology for physician payment
- Creates a new methodology:
 - The Quality Payment Program



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Goals of the New Rule

- Introduce more flexible reporting options in year one
- Adjusts low volume threshold for small practices
- Establishes Advanced Alternative Payment Models (APM)
- Simplify the all or nothing EHR requirement
- Establish the medical home to improve care coordination

The Quality Payment Program

- Rewards the Delivery of High Quality Patient Care
- Creates two models:
 - Advanced Alternative Payment Models
 - Merit Based Incentive Payment System
- Will affect more than 600,000 eligible providers, according to CMS
- 60 day comment period in flight



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Fast Fact

Clinicians participating in Medicare serve more than 55 million of the country's seniors and individuals with disabilities, according to CMS



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Who Qualifies?

- Providers:
 - Physicians, Physicians Assistants
 - Nurse Practitioners, CRNAs, Clinical Nurse Specialists
- Who:
 - Bill Medicare more than \$30,000 annually
 - OR
 - Provide care for at least 100 Medicare patients annually



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Deciding which program to pick...

- This is not an option
- Providers may only participate in the program for which they qualify



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Alternative Advanced Payment Models



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Advanced Alternative Payment Models

- Payment Approaches provide added incentives to deliver high quality and cost efficient care
- Can apply to:
 - A specific condition
 - A care episode
 - A population
- Designed for Practitioners in specific value based care models
- CMS estimated that between 70,000 and 120,000 clinicians in 2017 will participate in and qualify for incentive payments under the APM path



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What qualifies as an advanced APM in 2017?

- The final rule identifies the following as advanced APMs for 2017:
- Comprehensive End Stage Renal Disease Care Model
- Comprehensive Primary Care Plus Model
- Medicare Shared Savings Program Tracks 2 and 3
- Next Generation ACO Model



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Associated APM Rewards

- Providers who:
 - receive 25% payment through Medicare payments or:
 - see 20% of their Medicare patients through an Advanced APM in 2017
- Will earn a 5% incentive payment in 2019



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Merit-based Incentive Payment System



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Merit Based Incentive Payment System

- A new program for *certain* Medicare enrolled practitioners:
 - those participating in traditional fee for service Medicare
- Consolidates and sunsets components of 3 existing programs:
 - Physician Quality Reporting System
 - Physician Value Based Payment Modifier
 - Medicare EHR Incentive Program for Eligible Professionals
- CMS estimated that about 500,000 clinicians will be eligible to participate in MIPS in its first year



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MIPS' Focus

- A cohesive program that emphasizes:
 - Quality
 - Cost
 - Use of certified electronic technology
 - Avoidance of redundancies



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MIPS Scoring

- Quality 60 %
- Advancing Care Information 25 %
- Improvement Activities 15%



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MIPS Overall Payment Model

- Payment adjustments in the first year will be neutral, positive or negative up to 4 percent
- This will grow to 9 percent by 2022



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Pick your Pace Implementation



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When does the Program start?

- Several options are provided:
 - If prepared providers can begin collecting data on January 1st 2017
 - May also elect to begin collecting data anytime between January 1st and October 2nd
- Data for either option is due to CMS no later than March 31st, 2018
- Will determine payment adjustments beginning January 1st 2019



MIPS Reporting Options



MIPS Overall Requirements

- Report on up to 6 quality measures, including at least one outcomes measure, for a minimum of 90 days within the attestation window
- Groups will need to report on 15 quality measures for a full year
- Attest to completing up to 4 quality improvement activities for a minimum of 90 days
- Complete the security risk analysis and attest to the ability to conduct e-Prescribing, provide patient access to data, send summaries of care, and request/accept summaries of care



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Individual Reporting

- May report as an individual provider based upon NPI number
- Individual data for each of the MIPS categories to be submitted through any of the following methods:
 - a certified electronic health record
 - A qualified clinical data registry,
 - routine Medicare claims processing



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Group Reporting

- A group is defined as
 - a set of clinicians (identified by their NPIs) sharing a common Tax Identification Number
 - no matter the specialty or practice site
- MIPS data submitted as a group, will get one payment adjustment
- based on the group's overall performance
- Group data for each of the MIPS categories to be submitted through any of the following methods:
 - Through the CMS web interface
 - **To submit data through the CMS web interface, you must register as a group by June 30, 2017**
 - a third-party data-submission service such as a certified EHR
 - registry
 - a qualified clinical data registry



Selecting Measures to Report

- At a minimum, the following factors should be considered when selecting measures for reporting:
 - Clinical conditions usually treated
 - Types of care typically provided – e.g., preventive, chronic, acute
 - Settings where care is usually delivered – e.g., office, emergency department (ED), surgical suite
 - Quality improvement goals for 2016
 - Other quality reporting programs in use or being considered



Quality Measure Selection

- 271 Available
- Review and select measures that best fit your practice.
- Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
- If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.



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“Advancing Care Information” Replaces MU in MIPS

- Total Number of required measures reduced to 5:
 - Security risk analysis
 - E-prescribing;
 - Provide patient access
 - Send summary of care
 - Request/accept summary of care
- Optional Measures will be available to increase score



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Advancing Care Information

- 2 options:
- In 2017, there are two measure set options for reporting. The option you use to submit your data is based on your electronic health record edition.
- **Option 1:** Advancing Care Information Objectives and Measures-15 available
- **Option 2:** 2017 Advancing Care Information Transition Objectives and Measures-11 available



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Improvement Activities

- **Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days.
- **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days.
- **Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:** You will automatically earn full credit.
- **Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model:** You will automatically be scored based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.
- **Participants in any other APM:** You will automatically earn half credit and may report additional activities to increase your score



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Transition Year Bonuses

- Improvement Activities including:
 - Utilizing Certified EHR technology
 - Reporting to Public Health Agencies
 - Reporting to Clinical Data Registries
- A 5 percent bonus credit will be awarded to providers who report on public health measures and participate in a clinical data registry reporting program



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Are small practices able to participate?

- Providers who fall below the requirements of at least \$30,000 Medicare charges or 100 Medicare patients are exempt from participating in 2017
- CMS estimates this represents 32.5 percent of clinicians, accounting for only 5 percent of Medicare spending
- CMS is offering an option for small practices and solo physicians to join together in virtual groups and submit combined MIPS data
- The final rule also allots \$20 million a year for five years for training and education of physicians in practices of 15 or fewer and those who work in underserved areas



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Compliance Considerations for MACRA

- Significant focus on ICD 10 Specificity and associated documentation
- Increased emphasis on specialty specific measure selection
- Laser focus on physicians participating in ACOs applying to participate in MIPS
- Focus on HCCs especially for APMs
- Physician Documentation will need increased specificity and clarity
- Coders can assist by taking a lead in assisting physicians and office staff's understanding of the codes required for the various selected measures



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Resources

- CMS MACRA Website:
 - <https://qpp.cms.gov/>
 - <https://qpp.cms.gov/resources/education>
 - [https://qpp.cms.gov/docs/QPP Where to Go for Help.pdf](https://qpp.cms.gov/docs/QPP%20Where%20to%20Go%20for%20Help.pdf)
- AAPC:
 - <https://www.aapc.com/blog/34697-clinicians-know-about-macra-mips-apms/>



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Thank you

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