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On the topic:
What Every Practice Needs to Know about MACRA – Prepare Now to Become a Data Driven Practice

Meet the Presenter…

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What Every Practice Needs to Know about MACRA –
Prepare Now to Become a Data Driven Practice

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Overview

• The Changing Payment Model
• MACRA, MIPS, and APM goals defined
• Medical Necessity, Payer Contracts and LCD’s
• Coders, Clinicians, and Providers – “The Team”
• How To Prepare
• Tools, Tips, and Techniques
Changing Payment Model

• On April 14, 2015, the US Senate voted (98-2) to permanently repeal the highly criticized Medicare Part B Sustainable Growth Rate (SGR) reimbursement formula and passed the “Medical Access and CHIP Reauthorization Act of 2015” (MACRA), creating a new, pay-for-performance oriented Medicare reimbursements program.
Moving Forward

• On May 9, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule for implementing changes to the value-based reimbursement (VBR) scheme required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

• The proposed rule introduces the Quality Payment Program (QPP), which implements the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

• On October 14, 2016, Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services released the final rule:
  – The 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

• The final rule is scheduled to be published in the Federal Register on November 4, 2016

Source: https://qpp.cms.gov/docs/CMS-5517-FC.pdf
MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

MACRA contains:
- Physician Fee Schedule (PFS) updates
- New Merit-Based Incentive Payment System (MIPS)
- New Technical Advisory Committee for assessing Physician Focused Payment Model (PFPM) proposals
- Incentive payments for participation in Alternative Payment Models (APMs)
History Lesson

• Payment reform has long been discussed in healthcare, as escalating costs have called for changes to the traditional fee-for-service model.

• The urgency to lessen the burden of healthcare cost has reached new levels and has proven statistics reflective that we’re getting poor value for our money.

• Just how heavy is the burden of healthcare costs?
By tying payments to outcomes and quality of care, MACRA becomes bigger than just reimbursements.

As part of the Affordable Care Act, the Department of Health and Human Services is encouraging providers to adopt the “patient-centered medical home” model of care delivered by physician teams, all of whom are responsible for and measured on patient outcomes.
...and toward transforming our health care system.

3 goals for our health care system:

- BETTER care
- SMARTER spending
- HEALTHIER people

Via a focus on 3 areas

- Incentives
- Care Delivery
- Information Sharing

MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare

**Medicare Fee-for-Service**

**GOAL 1:**
Medicare payments are tied to quality or value through alternative payment models (categories 2-4) by the end of 2016, and 50% by the end of 2018

**GOAL 2:**
Medicare fee-for-service payments are tied to quality of value (categories 2-4) by the end of 2016, and 90% by the end of 2018

**STAKEHOLDERS:**
- Consumers
- Businesses
- Payers
- Providers
- State Partners

Set internal goals for HHS

Invite private sector payers to align or exceed HHS goals
MACRA moves us closer to meeting these goals...

The new Merit-based Incentive Payment System helps to link fee-for-service payments to quality and value.

The law also provides incentives for participation in Alternative Payment Models in general and bonus payments to those in the most highly advanced APMs.

New HHS Goals:

<table>
<thead>
<tr>
<th>Year</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>%</td>
<td>85%</td>
<td>90%</td>
</tr>
</tbody>
</table>

- All Medicare fee-for-service (FFS) payments (Categories 1-4)
- Medicare FFS payments linked to quality and value (Categories 2-4)
- Medicare payments linked to quality and value via APMs (Categories 3-4)
- Medicare Payments to those in the most highly advanced APMs under MACRA

MACRA Goals

Through MACRA, HHS aims to:

- Offer **multiple pathways** with varying levels of risk and reward for providers to tie more of their payments to value.
- Over time, **expand the opportunities** for a broad range of providers to participate in APMs.
- **Minimize additional reporting burdens** for APM participants.
- **Promote understanding** of each physician’s or practitioner’s status with respect to MIPS and/or APMs.
- **Support multi-payer initiatives** and the development of APMs in Medicaid, Medicare Advantage, and other payer arrangements.
What is MIPS?

- Effective January 1, 2019, the “Meaningful Use” (MU) Electronic Health Record Incentive Program, Physician Quality Reporting System (PQRS), and Value-Based Modifier (VBM) program will be consolidated into the new Merit-based Incentive Payment System (MIPS) program.

- This new program will merge and strengthen the financial impact of the various measurement and reporting tools, along with claims-based financial considerations that have become familiar since the adoption of digital health records.

- According to CMS, “to implement the quality category of the MIPS, CMS anticipates using the measures in the existing quality programs (PQRS, VM and EHR).”
MIPS changes how Medicare links performance to payment

There are currently multiple individual quality and value programs for Medicare physicians and practitioners:

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier
- Medicare EHR Incentive Program

MACRA streamlines those programs into MIPS:

Merit-Based Incentive Payment System (MIPS)

How will physicians and practitioners be scored under MIPS?

A single MIPS composite performance score will factor in performance in 4 weighted performance categories:

- Quality
- Resource use
- Clinical practice improvement activities
- Meaningful use of certified EHR technology
A provider’s “MIPS score,” rated on a scale from 0 to 100, will significantly influence a Medicare reimbursement payment each year.

This will translate into four areas of consideration to be scored as follows:

– 30% by VBM-measured resource use (claims data),
– 30% by VBM-measured quality (PQRS data),
– 25% by Meaningful Use (EHR data), and
– 15% by a newly introduced “clinical practice improvement” measure.

https://qpp.cms.gov/measures/quality
**Acute Otitis Externa (ACE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use**

Percentage of patients aged 2 years and older with a diagnosis of ACE who were not prescribed systemic antimicrobial therapy.

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>NQF Domain</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>eMeasure ID: N/A</td>
<td>Efficiency and Cost Reduction</td>
<td>Process</td>
</tr>
<tr>
<td>eMeasure NQF: N/A</td>
<td>Quality ID: 093</td>
<td></td>
</tr>
<tr>
<td>NQF 0654</td>
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<td></td>
</tr>
</tbody>
</table>

**High Priority Measure:**
- Yes

**Data Submission Method:**
- Claims
- Registry

**Specialty Measure Set:**
- Emergency Medicine
- Otolaryngology
- General Practice/Family Medicine
- Pediatrics

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**How does MACRA provide additional rewards for participation in APMs?**

Most physicians and practitioners who participate in APMs will be subject to MIPS and will receive favorable scoring under the MIPS clinical practice improvement activities performance category.

Those who participate in the most advanced APMs may be determined to be qualifying APM participants (“QPs”). As a result, QPs:
1. Are not subject to MIPS
2. Receive 5% lump sum bonus payments for years 2019-2024
3. Receive a higher fee schedule update for 2026 and onward
ADVANCED PAYMENT MODEL (APM)

How do I become a qualifying APM participant (QP)?

QP's are physicians and practitioners who have a certain % of their patients or payments through an eligible APM.

Beginning in 2021, this threshold % may be reached through a combination of Medicare and other non-Medicare payer arrangements, such as private payers and Medicaid.

QP's:
1. Are not subject to MIPS
2. Receive 5% lump sum bonus payments for years 2019–2024
3. Receive a higher fee schedule update for 2026 and onward
Potential value-based financial rewards

- APMs—and eligible APMs in particular—offer greater potential risks and rewards than MIPS.
- In addition to those potential rewards, MACRA provides a bonus payment to providers committed to operating under the most advanced APMs.

**MIPS only**
- MIPS adjustments

**APMs**
- APM-specific rewards
- MIPS adjustments

**eligible APMs**
- eligible APM-specific rewards
- 5% lump sum bonus

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**Not participating in the Quality Payment Program:**
If you don’t send in any 2017 data, you receive a negative 4% payment adjustment.

**Test:**
If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

**Partial:**
If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

**Full:**
If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

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**Participate in the Advanced APM path:**
If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, you earn a 5% incentive payment in 2019.

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The cycle of the program looks like this:
Advanced APMs

- Comprehensive ESRD Care (CEC) – Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
### Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Physician Fee</th>
<th>MIPS</th>
<th>Eligible APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 and earlier</td>
<td>0.5</td>
<td>4%</td>
<td>Qualifying APM Participant</td>
</tr>
<tr>
<td>2016</td>
<td>0.5</td>
<td>5%</td>
<td>Excluded from MIPS</td>
</tr>
<tr>
<td>2017</td>
<td>0.5</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>0</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>0</td>
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<td></td>
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<tr>
<td>2022</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2024 and later</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Physician Fee Schedule Updates
- MIPS Meaningful Use
- Clinical Practice Improvement Activities
- Advanced Use of Certified EHR Technology
- PCS: Unique Identifiers
- Qualified APM

Maximum MIPS Payment Adjustment (+/-):

- QAPM (Qualifying APM conversion factor)
- COPM (Non-Qualifying APM conversion factor)

### Independent PFPM Technical Advisory Committee

**PFPM = Physician-Focused Payment Model**

Encourage new APM options for Medicare physicians and practitioners.

- **Submission of model proposals**
- **Technical Advisory Committee** (CMS-appointed care delivery experts)
- Secretary comments on CMS website, CMS considers testing proposed model

Review proposals, submit recommendations to HHS Secretary.
Who Will Be Impacted?

• Every eligible provider with claims to Medicare. MIPS scores will result in either bonus or penalty payment adjustments. There is no score that will not affect reimbursement.

• For the years 2019 and 2020, the following providers are MIPS-eligible professionals:
  – physicians, physician assistants,
  – nurse practitioners, clinical nurse specialists, and nurse anesthetists.

• Beginning in 2021 and further, the following providers also become MIPS-eligible:
  – physical or occupational therapists,
  – speech-language pathologists,
  – audiologists,
  – nurse midwives, clinical social workers, clinical psychologists, and dietitians or nutrition professionals.

Are There Any Exceptions to MIPS?

• Exempted clinicians include those newly enrolled in Medicare

• Those who have less than or equal to $30,000 in Medicare charges and less than 100 Medicare patients during the performance year, or

• Those who qualify as an APM participant.
Transitioning…

• The initial development of the QPP implementation would allow physicians to pick their pace of participation for the first performance period that begins January 1, 2017.

• Eligible clinicians will have three flexible options to submit data to MIPS and a fourth option to join APMs in order to become QPs, which would ensure they do not receive a negative payment adjustment in 2019.
Option #1

• Clinicians can choose to report to MIPS for a full-day period or, ideally, the full year, and maximize the MIPS eligible clinician’s chances to qualify for a positive adjustment.

• In addition, MIPS eligible clinicians who are exceptional performers in MIPS, as shown by the practice information that they submit, are eligible for an additional positive adjustment for each year of the first 6 years of the program.

Option #2

• Clinicians can choose to report to MIPS for a period of time less than the full year performance period 2017 but for a full 90-day period at a minimum and report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information performance category in order to avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment.
Option #3

- Clinicians can choose to report one measure in the quality performance category; one activity in the improvement activities performance category; or report the required measures of the advancing care information performance category and avoid a negative MIPS payment adjustment.

- Alternatively, if MIPS eligible clinicians choose to not report even one measure or activity, they will receive the full negative 4 percent adjustment.

Option #4

- MIPS eligible clinicians can participate in Advanced APMs, and if they receive a sufficient portion of their Medicare payments or see a sufficient portion of their Medicare patients through the Advanced APM, they will qualify for a 5 percent bonus incentive payment in 2019.
How will the Quality Payment Program change my Medicare payments?

Depending on the data you submit by March 31, 2018, your 2019 Medicare payments will be adjusted up, down, or not at all. The information provided below is only relevant for the 2019 payment year. CMS will provide additional information on payment adjustments for 2020 and beyond beginning next year.

Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options:

- Don’t Participate
- Submit Something
- Submit a Partial Year
- Submit a Full Year

The Good News...

Starting in 2019, the existing Medicare quality reporting/incentive programs (PQRS, Value Based Modifier, and Meaningful Use) — which vary significantly in terms of measures, data submission options, and payment timelines — will be consolidated into one single quality improvement program, the Merit-Based Incentive Payment System (MIPS), reducing the significant confusion and hassles now associated with the current three separate reporting programs.

- The current Medicare reporting programs are not at all clear, transparent, or aligned in terms of performance thresholds that must be met. Under these programs, in 2019, physicians are faced with:
  - 2 percent penalty for failure to report PQRS quality measures;
  - 5 percent penalty for failure to meet EHR MU requirements; and
  - Additional potential negative adjustments under the Value-based Modifier (VBM) program (likely 4 percent or more)
- These penalties will be eliminated at the end of 2018, and physicians will be paid based on their MIPS-adjusted payment rate beginning January 1, 2019.
- This law puts the penalty money from the PQRS and Meaningful Use programs (in 2019 and beyond) into the physician payment pool, thereby providing increased funds available to pay physicians.

Source:
https://www.acponline.org/system/files/documents/advocacy/where_we_stand/assets/macra_handout/hr2_2015.pdf
Physician Compare

Physician Compare

Medicare.gov | Physician Compare

The Official U.S. Government Site for Medicare

Physician Compare Home | About Us | Glossary | OIG.gov | Medicare.gov | MyMedicare.gov Login

Resource

Find physicians and other health care professionals
Find group practices
Search another way

A field with an asterisk (*) is required.

* Location

ZIP code/City, State/Address/Location

* What are you searching for?

Search

Additional search options
Patient/Physician Engagement

- Both the patient experience and patient engagement are emerging variables in healthcare reimbursement.
- The patient experience is about perceptions; patient engagement is about actions and behaviors.
- Payment reform is creating a greater dependency on improving patient engagement for hospitals and providers.

Provider Performance Scores Will Become Public

- Over the next few years, healthcare consumers will be empowered to see their provider’s MIPS score and compare a provider’s score against his/her peers nationally.
Are you preparing now?

• The 2019 payment adjustment schedule will be based on the 2017 performance metrics.

• In other words, provider performance in 2017 will be measured by the new MIPS scoring model and will have a direct impact on 2019 reimbursements.

• In addition to the payment adjustment applied, each eligible professional's MIPS score and individual category scores will be made publicly available on the Physician Compare website, including a comparison of the ranges of scores for EPs across the country.

• The sooner you can ensure your practice performance the better prepared you'll be for 2019 MIPS implementation.
Clinician, Coder – Team Approach

- Promotes medical record accuracy in “telling the patient story”
- Improves coders clinical knowledge
- Improves communication between physician and other members of healthcare team
- More accurately reflects quality of care and outcome score
- Opportunity for continuing education

How to Prepare Your Practice

1. PQRS savvy – be aware of what measures you are successfully and unsuccessfully meeting.
2. Review top (10-15) diagnosis codes (how much money are you saving by keeping patients out of emergency department and expensive surgeries)
3. Track generic prescribing, how to reduce emergency department visits and 30-day readmits to hospital.
4. Review hospital demographics on patient length of stay, emergency admits/readmits.
5. Communicate with top payers and request “report card” on how you are doing in comparison with your physician peers.
Tools, Tips, and Techniques

- Educate your teams
- Explore MIPS data that your practice can submit for Quality, Improvement Activities, and Advanced Care Information (see Resource slide for link)
- Identify “unspecified” codes
- Review payor contract, LCDs for medical necessity
- Restructure your business practices to focus on value-based reimbursement

Resources

- **MACRA:**

- The Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs):