FLHSA

Finger Lakes Health Systems Agency

Preparing for Value Based Payment (introduction to MACRA)

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Goals of today talk:

1. Understand the change to Value Based Payment that MACRA is driving

2. Become familiar with the proposed rules affecting Medicare reimbursement

3. What practice changes are needed to succeed

The Background

- 1997 Congress passed legislation that established the Sustainable Growth Rate (SGR)
  - Fee for Service Payment for Physician services
  - Established a target on expenditures tied to the GDP
  - If the growth in expenditures exceeded the target there was to be an across the board cut in payments
  - From 2003 on each year a congressional fix was required to prevent the cut in physician payments

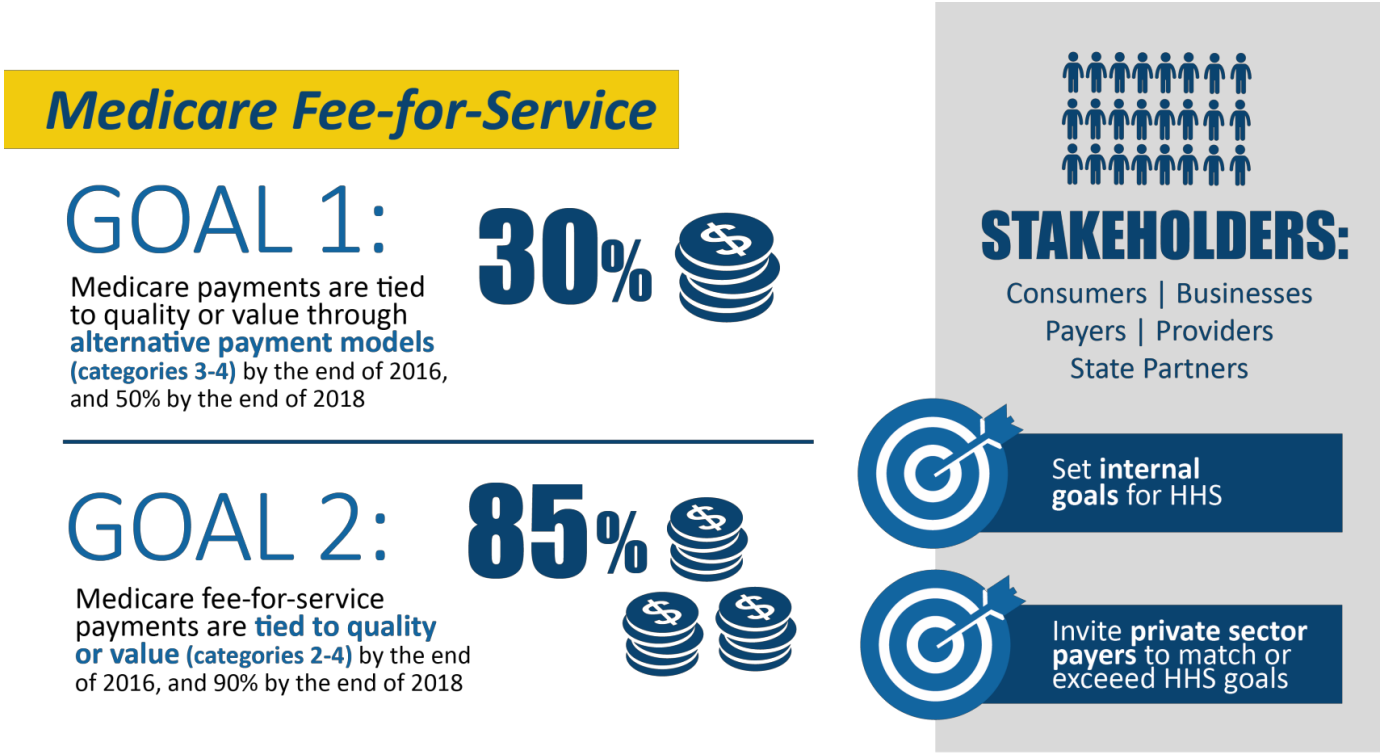
- Finally in 2015 the SGR was repealed by the Medicare Access and CHIP Reauthorization Act (MACRA)

What Does MACRA Stipulate

1. SGR repealed
2. 2015-2019 the physician fee schedule will increase by 0.5% per year and then no increases for the next 5 years. During that time the only increases in reimbursement will come from bonuses based on value based performance
3. All Medicare Part B payment will be part of the Quality Payment Program

The Quality Payment Program 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**

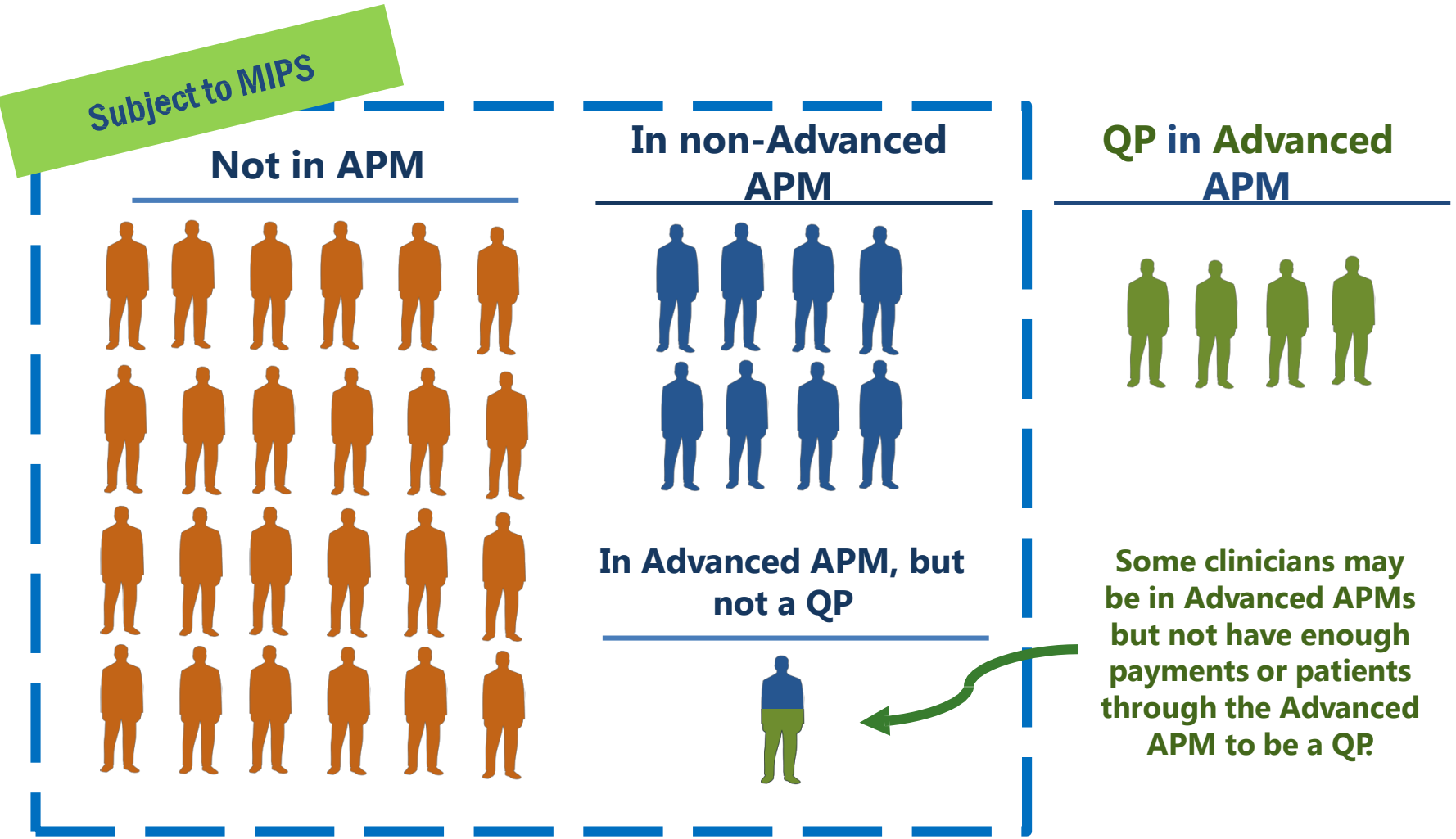


Quality Payment Program

- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

The Merit-based Incentive Payment System (MIPS)	or	Advanced Alternative Payment Models (APMs)

Note: Most practitioners will be subject to MIPS.



Note: Figure not to scale.

Advanced APMs

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

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, then you earn a 5% incentive payment in 2019.

How will the Quality Payment Program affect me?

Am I in an **Advanced** APM?

Yes

No

Am I in an **APM**?

Yes

No

Is this my **first year** in Medicare OR am I below the **low-volume threshold**?

Yes

No

Not subject to **MIPS**

Subject to **MIPS**

Do I have **enough payments or patients** through my Advanced APM?

Yes

No

Favorable MIPS scoring & APM-specific **rewards**

Qualifying APM Participant (QP)

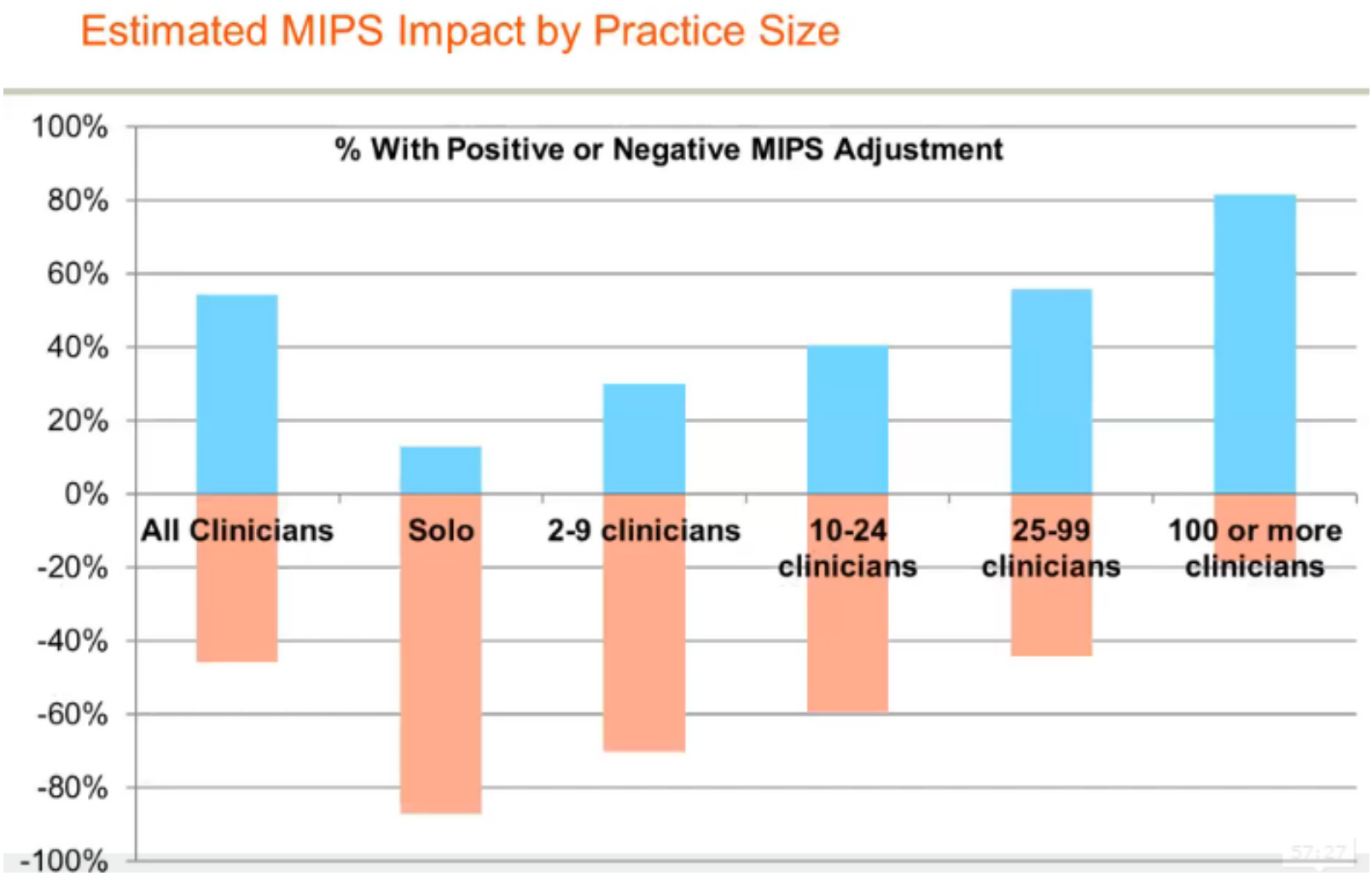
- **Excluded** from MIPS
- 5% lump sum **bonus payment** (2019-2024), higher **fee schedule updates** (2026+)
- APM-specific **rewards**

Bottom line: There will be **financial incentives for participating in an APM**, even if you don't become a **QP.**

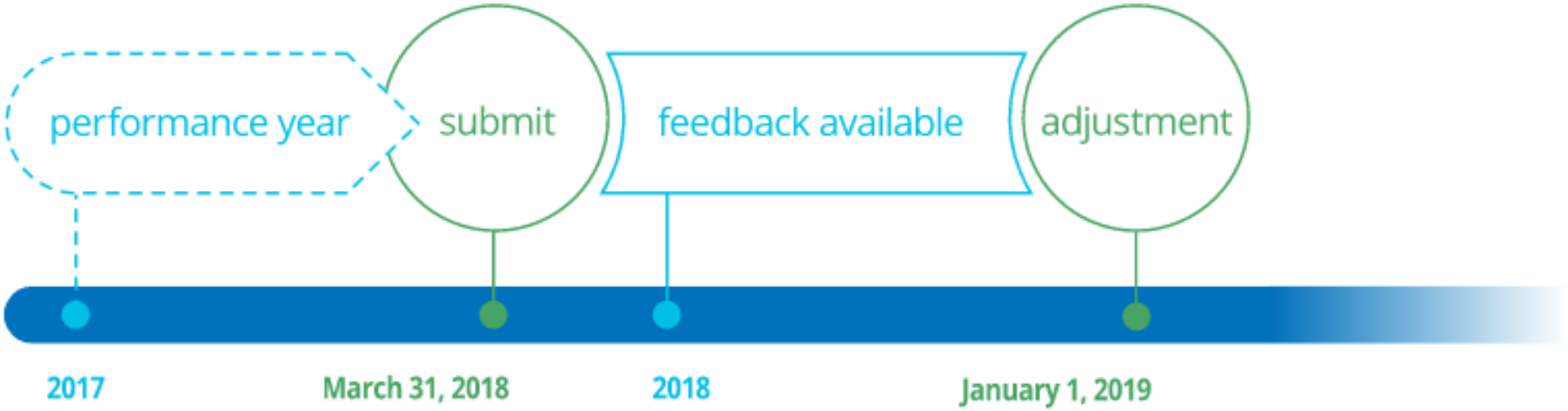
Criteria to be in MIPS Final Rule

- if you bill Medicare more than $30,000 a year and provide care for more than 100 Medicare patients a year, and are a:
- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

Initial proposed rule



Timing


performance year
submit
feedback available
adjustment
2017
March 31, 2018
2018
January 1, 2019

Reporting Options

Eligible Clinicians can participate in MIPS as an:

Or

Individual

Group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: "Virtual groups" will not be implemented in Year 1 of MIPS.

Reporting as an individual.

- If you send MIPS data in as an individual, your payment adjustment will be based on your performance. An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number.

- You'll send your individual data for each of the MIPS categories through an electronic health record, registry, or a qualified clinical data registry. You may also send in quality data through your routine Medicare claims process.

Reporting as a group.

- If you send your MIPS data with a group, the group will get one payment adjustment based on the group's performance. 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.
- Your group will send in group-level data for each of the MIPS categories through the CMS web interface or an electronic health record, registry, or a qualified clinical data registry. To submit data through the CMS web interface, you must register as a group by June 30, 2017.

Take these steps to get ready for 2017.

- Check that your electronic health record is certified by the Office of the National Coordinator for Health Information Technology. If it is, it should be ready to capture information for the MIPS advancing care information category and certain measures for the quality category.

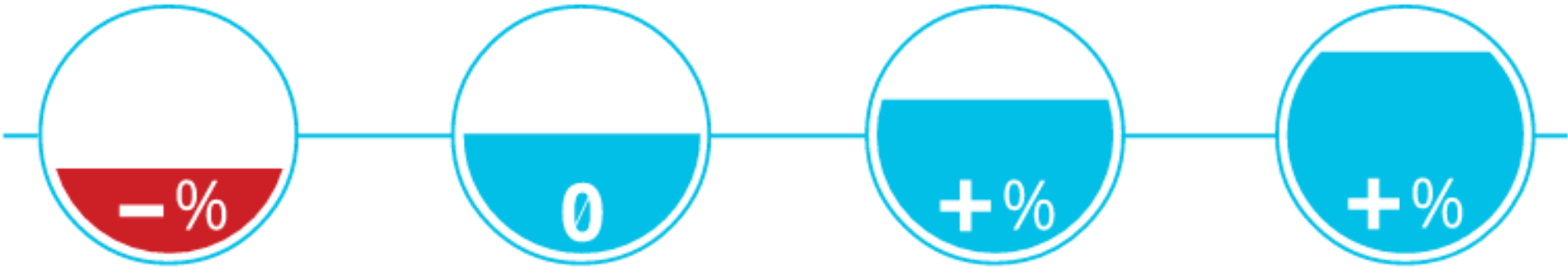
- Consider using a qualified clinical data registry or a registry to extract and submit your quality data.

- Use the CMS website to explore the MIPS data your practice can choose to send in. Check to see which measures and activities best fit your practice.

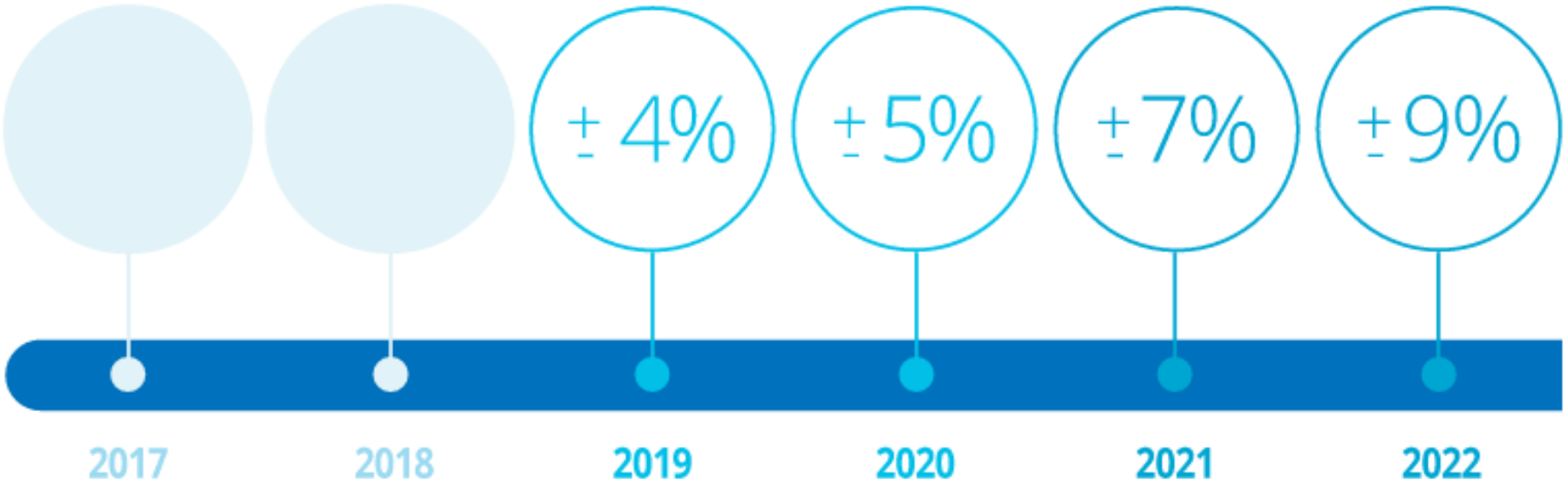
New options in the final rule

- If you're ready, you can begin January 1, 2017 and start collecting your performance data.
- If you're not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017.
- Whenever you choose to start, you'll need to send in your performance data by March 31, 2018.

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



Progression of bonus or penalty



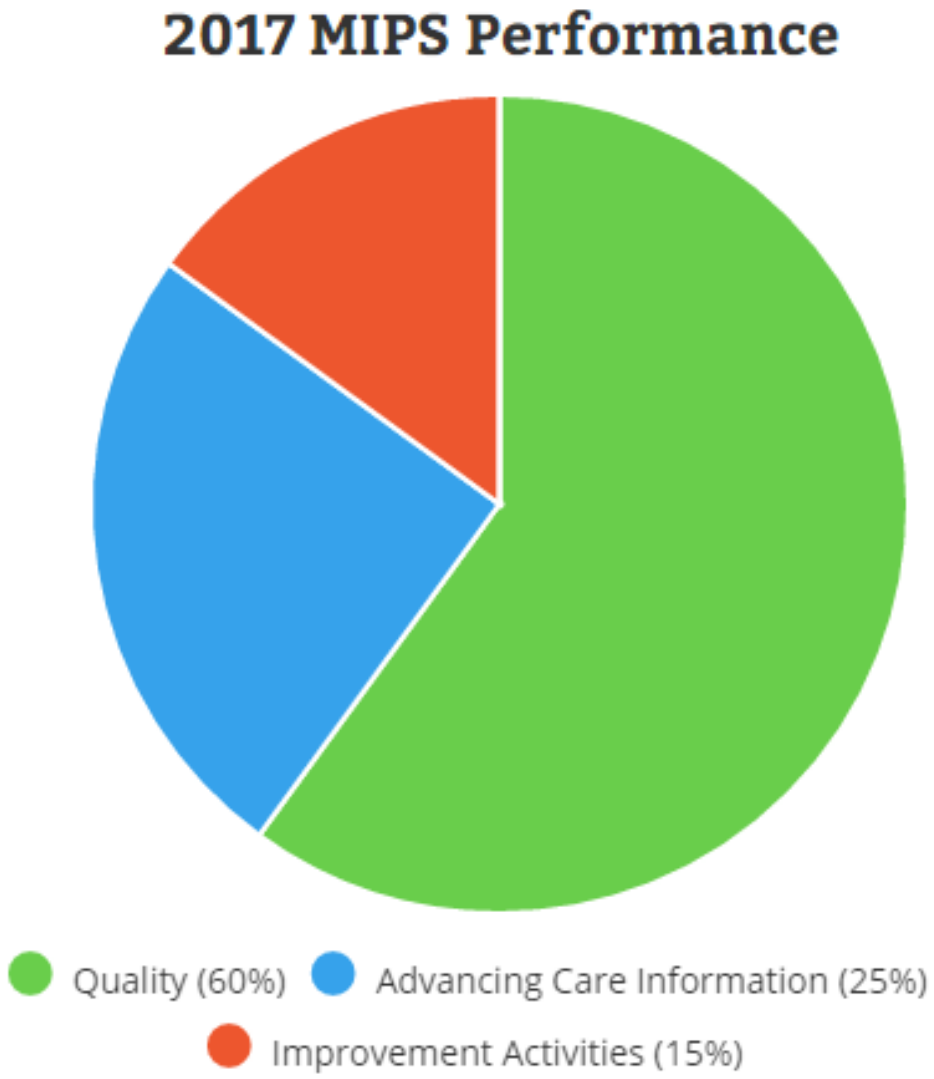
Measurement Categories

 **Quality**	 **Improvement Activities**
Replaces PQRS.	New category.
 **Advancing Care Information**	 **Cost**
Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.

Measurement Categories

Quality	Improvement Activities
2017	2017
Advancing Care Information	Cost
2017	2018

Measurement Categories



Quality

Replaces the Physician Quality Reporting System (PQRS).

WHAT DO YOU NEED TO DO?

Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.

Groups using the web interface: Report 15 quality measures for a full year.

Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for MIPS quality.

2017 CATEGORY WEIGHT

60%

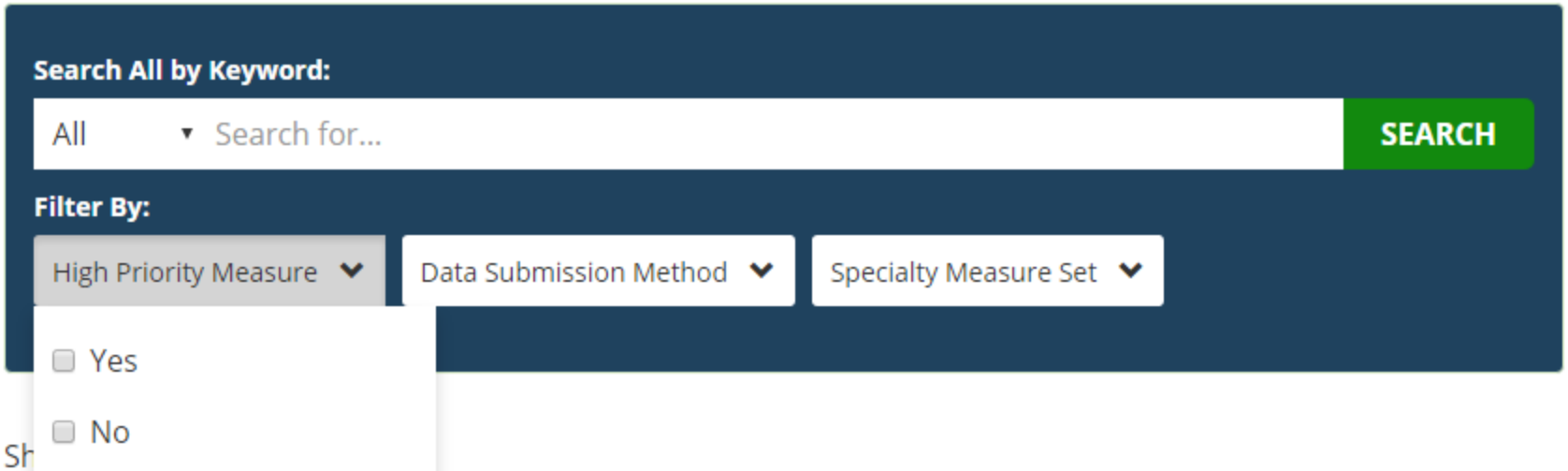
Quality Measures

CMS: https://qpp.cms.gov/measures/quality

1. Select up to 6 measures that best fit your practice
2. Include 1 cross-cutting measure and1 outcome measure
3. If an outcome measure is not available for your practice choose another high priority measure
4. Population measures automatically calculated

Groups in APMs qualifying for special scoring standards such as Shared Savings Track 1 report quality measures through your APM

Select Measures



Select Measures

Search All by Keyword:

All ▾ Search for... SEARCH

Filter By:

High Priority Measure ⌄ | Data Submission Method ⌄ | Specialty Measure Set ⌄

- Administrative Claims
- Claims
- CSV
- CMS Web Interface
- EHR
- Registry

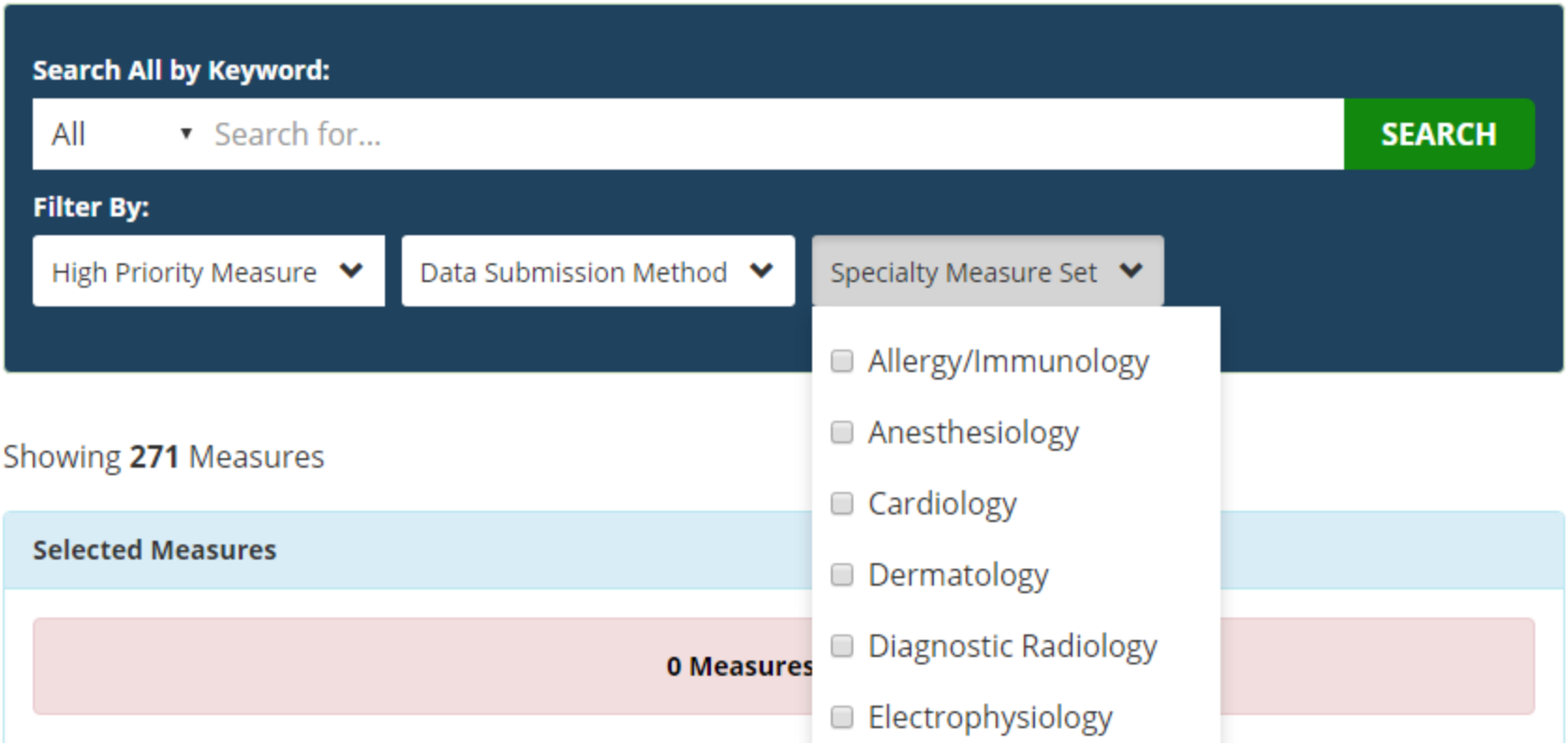
Showing **271** Measures

Selected Measures

s Added

Once you select measures th

Select Measures



Advancing Care Information

Replaces the Medicare EHR Incentive Program, also known as Meaningful Use.

WHAT DO YOU NEED TO DO?

Fulfill the required measures for a minimum of 90 days:

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care

Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

For bonus credit, you can:

- Report Public Health and Clinical Data Registry Reporting measures
- Use certified EHR technology to complete certain improvement activities in the improvement activities performance category

OR

You may not need to submit advancing care information if these measures do not apply to you.

https://qpp.cms.gov/measures/aci

Select Measures

Advancing Care Information Objectives & Measures | 2017 Advancing Care Information Transition Objectives & Measures

Showing **15** Measures

- Clinical Data Registry Reporting — ADD
- Clinical Information Reconciliation — ADD
- Electronic Case Reporting — ADD
- e-Prescribing — ADD
- Immunization Registry Reporting — ADD

Selected Measures

0 Measures Added

Once you select measures they will appear here

Improvement Activities

New category.

WHAT DO YOU NEED TO DO?

Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days.

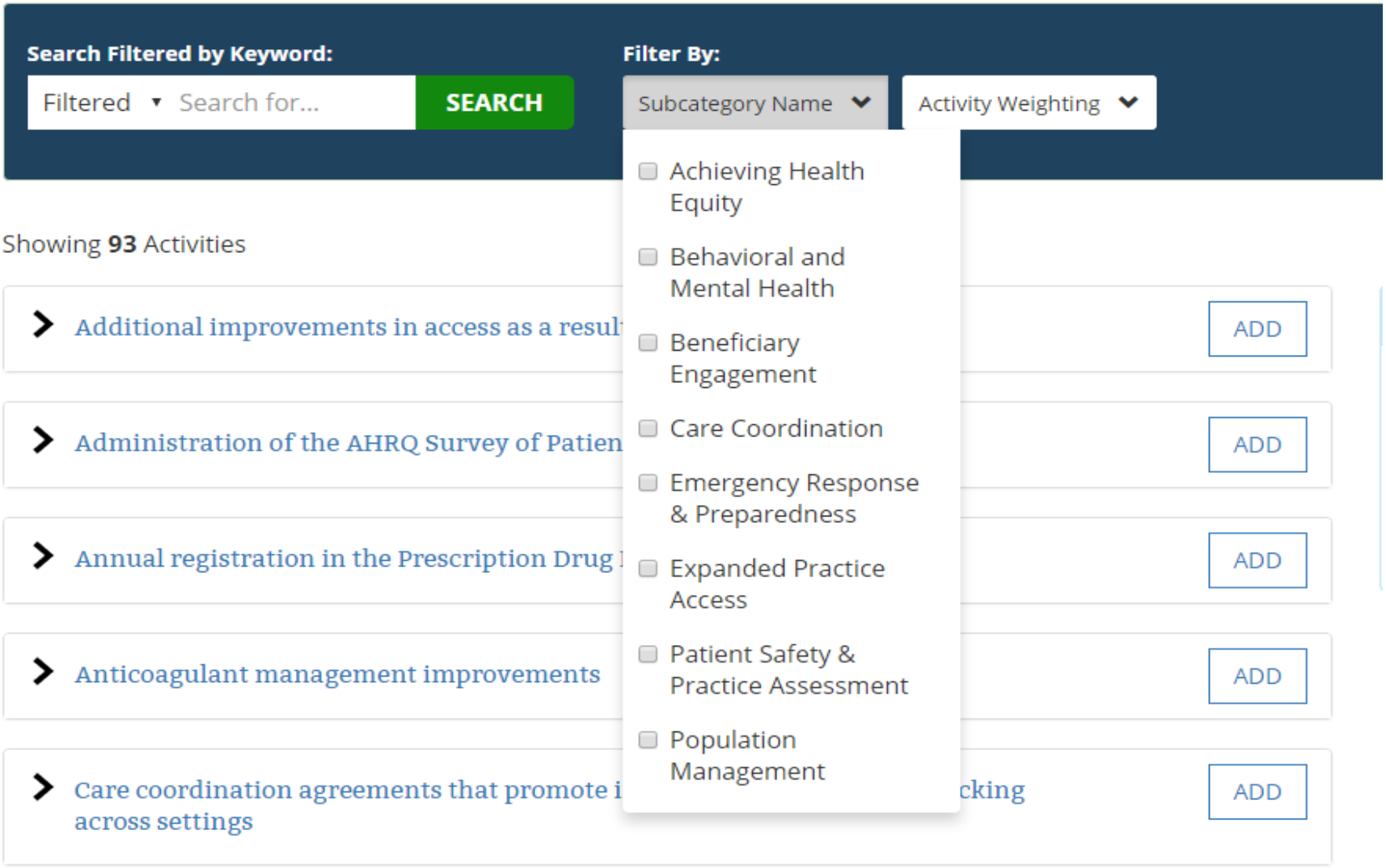
Groups with fewer than 15 participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.

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 receive points 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.

https://qpp.cms.gov/measures/ia

Select Improvement Activities



Cost

Replaces Value-Based Modifier.

WHAT DO YOU NEED TO DO?

No data submission required. Calculated from adjudicated claims.

2017 CATEGORY WEIGHT

Counted starting in 2018

That's the Rule
So what do I do?

- Don't panic but don't delay. Measurement starts in 2017 and not reporting will result in negative adjustments to Medicare payments in 2019. Don't get caught by the 2 year lag between reporting and fee changes.

- Explore with the care delivery organizations (IPAs, ACOs) you are participating in their plans related to Value Based Payment. There is risk but significant rewards in the Advanced APM track

So what do I do? (continued)

- Decide who in the practice can take ownership of this change and empower them to lead the efforts
- Enroll to get your QRUR – Quality and Cost Report generated by CMS
- Your professional societies are a good resource for both information and advocacy

So what do I do? (continued)

- There are programs to assist practices, take advantage while they are available at no cost to the practice:
  - Transforming Clinical Practice Initiative
  - NY State Innovation Model for Advanced Primary Care
  - MACRA technical assistance for rural and small practices
  - DSRIP funded assistance to meet their goals of all practices reaching PCMH or APC

- Contacts:
  - Lisa Noel: lnoel@nyacp.org ; 518-427-0366

What new skills do I need to incorporate in the practice to succeed

- Leadership
- Team based care
- Empanelment
- Enhanced Access
- Population health with risk assessment for all patients
- Care coordination
- Care management
- Integration of behavioral health

Finger Lakes Health Systems Agency

Finger Lakes Health Systems Agency is the region's health planning center. Through extensive data collection and analysis, the agency identifies community needs, then brings together residents, hospitals, insurers, physicians and other community partners to find solutions. Located in Rochester, FLHSA serves the nine counties of Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates.

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