Webinar Q&A: The Secret to High Performance Under MACRA

This document was compiled from questions asked during the July 20, 2016 webinar "*The Secret to High Performance Under MACRA.*"

Does MACRA apply to specialists?

Yes. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals the sustainable growth rate methodology for updates to the physician fee schedule (PFS) and replaces it with a new Merit-based Incentive Payment System (MIPS) for eligible clinicians or groups under the PFS. It also establishes incentives for participation in certain alternative payment models. MIPS eligible clinicians will include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians.

Are hospitals subject to MACRA and/or MIPS?

Medicare Part B payments are subject to MACRA, including in-patient. Like other providers, hospitalists that are part of an Advanced APM fall under the Advanced APM; hospitalists who are not part of an Advanced APM are subject to MIPS.

Are Federally Qualified Health Centers exempt?

Yes, services provided under an FQHC's all-inclusive payment methodology are exempt from MIPS.

According to the proposed rule, the MIPS adjustment is applied to the amount otherwise paid under Part B with respect to the items and services furnished by a MIPS eligible clinician during a year. Some eligible clinicians may not receive MIPS adjustments due to their billing methodologies. If a MIPS eligible clinician furnishes items and services in an RHC and/or FQHC and the RHC and/or FQHC bills for those items and services under the RHC's or FQHC's all-inclusive payment methodology, the MIPS adjustment would not apply to the facility payment to the RHC or FQHC itself. However, if a MIPS eligible clinician furnishes other items and services in an RHC and/or FQHC and bills for those items and services under the PFS, the MIPS adjustment would apply to payments made for items and services.

Are you finding it meaningful for providers to utilize the AWV program which has the ability to easily tie CCM to the AWV visit and seamless to enroll them on the spot?

Yes. The information gathered during the AWV, including disease risks, health recommendations, and preventative measures, transitions easily into a CCM discussion.

Note: Healthcare law governing documents such as this is quite complicated and subject to change and interpretation. Before using this information be sure to obtain advice from your own counsel to assure that this information is in compliance to existing healthcare law.

What is an AWV?

The Medicare Annual Wellness Visit (AWV) is a yearly appointment to develop or update a personalized prevention plan to prevent disease and disability based on current health and risk factors. The AWV visit is not a head-to-toe physical exam, but rather a prevention based visit that includes a review of medical and family history, current list of medications, detection of any cognitive impairment, routine measures such as height and weight, identification of risk factors and treatment options, and personalized health advice. The Part B deductible doesn't apply, so this visit is entirely free for Medicare patients. Note that patients cannot receive an AWV within the first year they are enrolled in Medicare or within the same year they have their Welcome to Medicare exam.

Can participants in an APM such as OCM enroll patients in CCM as well?

According to the Oncology Care Model FAQs and Applications published on April 22, 2015, practices that bill the OCM PBPM cannot also bill for CCM or TCM services in the same month for the same beneficiary. Participants in OCM can bill for CCM in months that OCM PBPM is not billed to help monitor the status of patients, identify potential issues before escalation, reduce the cost of care, and improve performance on quality measures.

https://innovation.cms.gov/Files/transcripts/OCM-FAQ-App-trans.pdf

Will all levels of PCMH receive full credit for CPI?

In the current Proposed Rule, Patient Centered Medical Home (PCMH) will be recognized if it is a nationally recognized accredited PCMH, Medicaid Medical Home Model, or Medical Home Model. The National Committee for Quality Assurance (NCQA) Patient-Centered Specialty Recognition will also be recognized, which qualifies as a comparable specialty practice. Nationally recognized accredited patient-centered medical homes are recognized if they are accredited by: (1) the Accreditation Association for Ambulatory Health Care; (2) the National Committee for Quality Assurance (NCQA) PCMH recognition; (3) The Joint Commission Designation; or (4) the Utilization Review Accreditation Commission (URAC).

By PCMH do you mean the Horizon Program or NCQA? Medicare doesn't have a PCMH program, correct?

According to the MACRA proposed rule, a patient-centered medical home will be recognized if it is a nationally recognized accredited patient-centered medical home, a Medicaid Medical Home Model, or a Medical Home Model. The NCQA Patient-Centered Specialty Recognition will also be recognized, which qualifies as a comparable specialty practice. Nationally recognized accredited patient-centered medical homes are recognized if they are accredited by: (1) the Accreditation Association for Ambulatory Health Care; (2) the National Committee for Quality Assurance (NCQA) PCMH recognition; (3) The Joint Commission Designation; or (4) the Utilization Review Accreditation Commission (URAC).

A MIPS eligible clinician or group that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, with respect to a performance period must be given the highest potential score for the CPIA performance category for the performance period. MIPS eligible clinicians or groups who are participating in an APM (as defined in section 1833(z)(3)(C) of the Act) for a performance period must earn at least one half of the highest potential score for the CPIA performance category for the performance period.

How do you know if you should join as APM or MIPS?

The majority of APM's are subject to MIPS. Only Advanced APM's are except from MIPS. To be an Advanced APM, an APM must meet three requirements:

- Participants are required to use certified EHR technology
- Payment for covered professional services is based on quality measures comparable to those used in the quality performance category of MIPS
- Be either a Medical Home Model expanded under section 1115A of the Act or bear more than a nominal amount of risk for monetary loss.

Solo practitioners and smaller clinics are projected to be the hardest hit by negative payment adjustments. This is largely because controlling cost and quality requires tight collaboration and coordination across all providers and settings, which is more easily achieved by groups that have co-management agreements in place and have agreed to share risk and reward. APM's, whether they are independent physician-led groups such as an IPA or a large health system, can pool risk, pool resources to implement the necessary improvements in processes and technology, and participate in co-management agreements that will help to improve care coordination . Therefore if you are not currently in an APM, it makes sense to explore your options here.

We are signed up to be part of an ACO in 2017. Does that mean we will not be subject to MIPS?

If you are in an Advanced APM, you will not be subject to MIPS. All other APMs are subject to MIPS. Advanced APMs include the Comprehensive ESRD Care Model (Large Dialysis Organization arrangement), Comprehensive Primary Care Plus, Medicare Shared Savings Tracks 2 and 3, and the Oncology Care Model Two-Sided Risk arrangement.

We are hoping to participate in CPC+ but if our region is not selected, how will our payment model change?

If your region is not selected, you will be subject to MIPS instead of being considered an Advanced APM.

Will we be able to get a copy of slides?

The slides are available for Smartlink customers.

How do you sign up for APM?

There are a variety of alternative payment models currently being tested by the CMS alternative payment model. You can find out if there are any in your area by visiting https://innovation.cms.gov/index.html. To learn more about the types of innovation models, please visit https://innovation.cms.gov/initiatives/#views=models.

Are any lab based services tied to MACRA legislation? Such as standard of care for each request for lab?

Yes. MACRA impacts all Part B services provided under the Physician Fee Schedule (PFS).

If a provider previously received an exemption under MU …how will this be handled? Particularly if that provider is now part of MSSP track 1?

It is possible for MIPS eligible providers to have the advancing care information performance category reweighted to zero due to hardship. To be considered for reweighting the advancing care information performance category for the 2019 MIPS payment year, applications must be submitted no later than March 31, 2018. An application would need to be submitted annually to be considered for reweighting each year. Section II.E.6 of the proposed rule provides more information regarding how the quality, resource use, and CPIA performance categories would be reweighted.

For MIPS eligible clinicians participating in the Shared Savings Program (which includes MSSP Track 1), all MIPS eligible clinicians participating in the APM Entity group submit under the Advancing Care Information category according to the MIPS requirements and have their performance assessed as a group through their billing TINs associated with the ACO. All of the ACO participant group billing TIN scores will be aggregated as a weighted average to yield one ACO group score. Any Shared Savings Program ACO participant billing TIN that does not submit data for the MIPS CPIA and/or advancing care information performance categories would contribute a score of zero for each performance category for which it does not report; and that score would be incorporated into the resulting weighted average score for the Shared Savings Program ACO. All MIPS eligible clinicians in the ACO (the APM Entity group) would receive the same score that is calculated at the ACO level (the APM Entity).

Also, do we have to sign up for MACRA like we do for PQRS and Meaningful Use or is it some kind of automatic data collection?

Under the proposed rule, the registration process (such as PQRS) is eliminated for groups submitting data using third party entities. When groups submit data utilizing third party entities, such as a qualified registry, health IT vendor, or QCDR, CMS is able to obtain group information from the third party entity and discern whether the data submitted represents group submission or individual submission.

For all other data submission methods, groups must work with appropriate third party entities to

ensure the data submitted clearly indicates that the data represents a group submission rather than an individual submission. In order for groups to elect participation via the CMS Web Interface or administration of the CAHPS for MIPS survey, CMS proposes that such groups must register by June 30 of the applicable 12-month performance period (that is, June 30, 2017, for performance periods occurring in 2017).

CMS proposes that MIPS eligible clinicians and groups may elect to submit information via multiple mechanisms; however, they must use the same identifier for all performance categories and they may only use one submission mechanism per category. For example, a MIPS eligible clinician could use one submission mechanism for sending quality measures and another for sending CPIA data, but a MIPS eligible clinician could not use two submission mechanisms for a single category such as submitting three quality measures via claims and three quality measures via registry.

CMS proposes one exception to the requirement for one reporting mechanism per category. Groups consisting of two or more eligible clinicians that elect to include CAHPS for MIPS as a quality measure must use a CMS-approved survey vendor. Their other quality information may be reported by any single one of the other proposed submission mechanisms.

Tables 1 & 2 below outline the specific data submission mechanisms for each performance category.

TABLE 1: Proposed Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually as TIN/NPI

Performance Category/Submission Combinations Accepted	Individual Reporting Data submission Mechanisms
Quality	Claims QCDR Qualified registry EHR Administrative claims (no submission required)
Resource Use	Administrative claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified registry EHR
CPIA	Attestation QCDR Qualified registry EHR Administrative claims (if technically feasible, no submission required)

"Dod-Frank Wall Street Reform 318 in the Last Year." *Federal Register.* Centers for Medicare & Medicaid Services, 9 May 2016, Web, table 1.

TABLE 2: Proposed Data Submission Mechanisms for Groups

Performance Category/Submission Combinations Accepted	Group Practice Reporting Data Submission Mechanisms
Quality	QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more) CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism.) and Administrative claims (no submission required)
Resource Use	Administrative claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)
CPIA	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more) Administrative claims (if technically feasible, no submission required)

"Dod-Frank Wall Street Reform 318 in the Last Year." *Federal Register.* Centers for Medicare & Medicaid Services, 9 May 2016, Web, table 2.