

SPRING/SUMMER 2016 EDITION

Medicare

Inside this Issue:

- Information on MACRA
- Office of Health Transformation Update
- GCOAT Acute Pain Prescribing Guidelines
- And Much More!

An Introduction to MACRA

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015. The law outlines many initiatives, but it primarily establishes new ways to pay physicians who care for Medicare Part B beneficiaries. This comprehensive legislation has the potential to significantly restructure the country's healthcare system.

The Federal Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) have been drafting rules based on the legislation since the law passed. The drafted rules are intended to provide the working guidelines for MACRA implementation, and they were recently in the comment period. The rules will then be revised and will likely be finalized for release and implementation in November.

A growing percentage of physician payment will be based on value, not on volume like the current fee-for-service system. To pay for value, it must be defined and indicators (or measures) of good care will be selected to evaluate performance. MACRA's value-based payment programs will be based on two new reimbursement structures: the Merit-Based Incentive Payments System (MIPS) and Alternative Payment Models (APMs).

Defining common measures may enable better care at lower cost. MACRA provides an opportunity to improve reporting accuracy and effectiveness, leading to reduced waste.

These changes will determine payment starting in 2019, so it's recommended that physicians learn all they can now and stay up-to-date on the latest information to be successful in the new environment.

To learn more about MACRA, [click here](#) for the AMCNO's web page on the topic. This section also contains links to other organizations that have created MACRA-specific pages.

Additional information on MACRA can be obtained at the following links:

<http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-physician-payment-reform.page>

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf>

CMS Announces Provider Enrollment Revalidation Requirements

The Centers for Medicare & Medicaid Services (CMS) has released information about the requirements for providers to enroll in revalidation cycle 2 to maintain Medicare billing privileges.

In accordance with 42 CFR §424.515, a provider must resubmit and recertify the accuracy of their enrollment information generally every 5 years. Revalidation ensures that a provider's enrollment information on file with Medicare remains complete and up-to-date.

Medicare providers who are due for revalidation are being encouraged to submit their application within 6 months of their due date or whenever they receive notification from their Medicare Administrative Contractors to revalidate.

If a provider fails to revalidate at the proper time, their enrollment is deactivated and Medicare claim payments will not be made. Deactivation also impacts a provider's ability to order, certify and prescribe.

CMS is currently defining the due date based on the last time the provider initially enrolled or revalidated, but some providers may be asked to revalidate in advance of the 5-year cycle. CMS reserves the right to conduct off-cycle revalidations in accordance with 42 CFR §424.515.

[Click here](#) to view the MLN article that covers revalidation cycle 2. And, to view a list of frequently asked questions, [click here](#).

HSAG Can Help Practices Use their QRUR to Improve Care

The Centers for Medicare & Medicaid Services (CMS)—through the CMS Physician Feedback Program—offers Quality and Resource Use Reports (QRURs) to help practitioners and group practices understand their performance on quality and cost metrics. The confidential QRUR feedback reports show how the Value-Based Payment Modifier (VBM) will apply to physician payments under the Medicare Physician Fee Schedule for those who bill under an individual or group Tax Identification Number in 2016. The reports provide comparative performance data that physicians can use to improve the care provided to Medicare beneficiaries.

The Health Services Advisory Group (HSAG) is the Medicare Quality Improvement Organization (QIO) for Ohio and will support practices in using QRUR data to identify opportunities to improve quality scores.

When [eligible professionals](#) partner with HSAG, they will be able to:

- Discover how to use QRURs to monitor clinical quality measures, increase incentive payments, and avoid the negative payment adjustment for the VBM.
- Receive virtual, one-on-one technical assistance to help them download and interpret their QRUR.
- Access timely updates, tools and resources related to VBM programs.

- Attend learning sessions to identify interventions, network to build relationships with stakeholders and community organizations, and implement workflows to improve processes and efficiencies for their patients.

For more information, [click here](#). Physicians can also contact Kim Harris-Salamone, PhD, HSAG Vice President, at 602-801-6960 or email her at ksalamone@hsag.com.

Now Available: 2016 PQRS Educational Materials

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of several 2016 PQRS educational materials. Some highlights include:

- The “2016 Implementation Guide,” available on the [PQRS How To Get Started web page](#), contains information for individual eligible professionals and PQRS group practices participating in 2016 PQRS.
- The 2016 PQRS measures documents, for those reporting via the claims and registry reporting mechanism, are located on the [PQRS Measures Codes web page](#).
- The 2016 group practice reporting option (GPRO) Web Interface measures documentation is available on the [PQRS GPRO Web Interface web page](#).
- The [PQRS Spotlight web page](#) contains a list of all recent documents and resources. Please check this page regularly for updates.

Be sure to look at the reporting mechanism-specific pages for “Made Simple” documents as well as other 2016 PQRS information. 2015 PQRS resources will be transferred to a separate web page following the 2015 submission period.

For questions regarding 2016 PQRS reporting, please contact the **QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222)** from 8 a.m. to 8 p.m. ET Monday—Friday, or via e-mail at gnetsupport@hcqis.org.

ICD-10 Compliance

The ICD-10 compliance date was Oct. 1, 2015, and the Centers for Medicare & Medicaid Services (CMS) released the [Next Steps Toolkit](#) to help providers track and improve their ICD-10 progress. This in-depth toolkit includes information on how to:

- Assess ICD-10 progress using key performance indicators to identify potential productivity or cash flow issues;
- Address opportunities for improvement; and
- Maintain progress and stay up-to-date on ICD-10.

CMS also released a companion [infographic](#) with simple steps from the Next Steps Toolkit.

Visit the CMS [ICD-10 website](#) and Roadto10.org for the latest news and official resources, including the Next Steps Toolkit, [ICD-10 Quick Start Guide](#), and a [contact list for provider Medicare and Medicaid questions](#).

The CGS Administrators Newsletter is Now Available on the AMCNO Website

The spring 2016 edition of the CGS Administrators J15 newsletter has been posted on the AMCNO website for review. This newsletter is provided to the AMCNO by CGS on a regular basis. The newsletter contains a wealth of information from CGS for providers and their staff. To view the newsletter, [click here](#).

Medicaid

ODH Releases Fact Sheet Outlining Medicaid's Coverage of Tobacco Cessation Services

Recently the Ohio Department of Health (ODH) and Medicaid updated their fact sheet on Medicaid's coverage of tobacco cessation services. Physicians can make an impact on reducing tobacco use by asking patients if they smoke and by providing brief counseling or referral to cessation resources.

The ODH has prepared a chart to assist physicians with this service. To view the chart [click here](#).

Office of Health Transformation Continues Work on Value-Based Payment Models

The Governor's Office of Health Transformation (OHT) recently hosted two webinars to update healthcare providers on Ohio's progress to financially reward practices that improve health outcomes while keeping the total cost of care down.

The first webinar focused on the Comprehensive Primary Care Payment Model. On June 8, Ohio Medicaid and the state's four largest commercial health insurance plans applied to the federal government to designate Ohio as a statewide comprehensive primary care region. If selected, Medicare, Medicaid and the commercial plans agree to provide enhanced reimbursement for advanced primary care beginning in January 2017. [Click here](#) to view the presentation, or [click here](#) to access the webinar.

The other webinar focused on the Episode-Based Payment Model. OHT reported that Ohio Medicaid is currently sending performance reports to specialists who are primarily responsible for 13 high-cost episodes of care (commercial plans are using similar reports), and OHT announced plans to design an additional 30 episodes in 2016. The information in the performance reports will be converted into referral reports for primary care practices to assist them in connecting their patients to high-value specialists. [Click here](#) to view the presentation, or [click here](#) to access the webinar. And, if clinicians wish to participate in the additional episode-based design process, they can click on [this link](#). OHT is looking for providers with expertise in Neonatal, HIV, ADHD and ODD.

Anthem

To access the Anthem June Provider update, [click here](#).

UnitedHealthcare

To access the UnitedHealthcare June bulletin, [click here](#).

To access the July bulletin, [click here](#).

Bureau of Workers' Compensation (BWC)

AMCNO Attends Ohio BWC Spring Stakeholder Meeting

The Ohio Bureau of Workers' Compensation (BWC) held its Spring Medical Provider Stakeholder meeting in May. AMCNO staff attended the event.

BWC Chief Medical Officer **Stephen Woods** provided details of the Provider Resource Report, a one-page practice overview that includes comparisons with peer groups of similar providers who treat BWC's injured workers. These reports allow providers to see the results of services they provide as they partner with the BWC to help injured workers return to work. Detailed definitions of terms used in the report as well as usage guides are available by clicking on the Ohio BWC website [here](#).


John Hanna, Director of the Pharmacy Department, discussed 2015 outcomes for the pharmacy program and 2016 initiatives, including individual physician prescribing reports. These automated report cards began mailing in June and contain prescribing patterns by drug class for the physician's patients. The reports compare the prescriber's habits to those among all physicians as well as to specialty physicians.

Another presenter, Chief of Medical Operations **Debi Kroninger**, provided an update on the Enhanced Care Program (ECP), which has been in place since July 1, 2015. The benefits of the program are improved health outcomes, simplified administrative processes, and increased reimbursement for the physicians who agree to participate in the program. Kroninger outlined which patients and physicians are considered eligible for the program. As of the end of April, 210 physicians have enrolled in the program, and 310 injured workers met all program criteria.

Tammie Mihaly, Manager of Provider Relations, gave an update on ICD-10 post-implementation. The BWC had formed a committee to plan for the ICD-10 transition well before the national compliance date, so that they would be ready for it by Oct. 1, 2015. What the bureau recognizes and treats are the legal allowance for a claim for workers' comp, not the ICD code. BWC provided two lists to assist providers: ICDs that are inappropriate for claim allowances, and a most frequently allowed codes list that includes ICD-9 to ICD-10, which may be used. Additional information about coding can be found on the Ohio BWC website by [clicking here](#).

You can view a video of the meeting in its entirety by [clicking here](#).

To access previous BWC provider newsletters, [click here](#).



News You Can Use

GCOAT Releases Acute Pain Prescribing Guidelines

The Governor's Cabinet Opiate Action Team (GCOAT) recently released [Guidelines for the Management of Acute Pain Outside of Emergency Departments](#) for outpatient management of acute pain expected to resolve within 12 weeks. The guidelines were drafted by the GCOAT, which included staff and physician representatives from the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), and staff from the AMCNO was on hand at the news conference when the official statement was released.

The guidelines recommend non-opioid treatment options when possible and limiting the amount of opioids used to treat acute pain where appropriate. They expand upon Ohio's prescribing guidelines for treating pain in emergency departments and acute-care facilities as well as for chronic pain, which were released in 2012 and 2013. As with those previous guidelines, these new guidelines are intended to supplement—not replace—clinical judgment. All three of these guideline sets were developed in conjunction with professional healthcare associations (including the AMCNO), state leaders and providers.

In recent years, both the number of opioid doses dispensed to Ohio patients and the number of “doctor shoppers” have decreased, according to data from the Ohio Automated Rx Reporting System (OARRS). But, there is more work to do. Prescription opioids remain a significant contributor to unintentional drug overdose deaths in Ohio, and the number of overdose deaths increased year-to-year from 2012 through 2014.

Visit www.opioidprescribing.ohio.gov to review the new guidelines as well as the others that were previously released. Also on the website are prescriber tools and resources, including a letter to give patients that explains a safer approach to treating their acute pain following these guidelines.

You can [read the news release here](#) from the Governor’s Office about the new prescribing guidelines.

And [learn more here](#) about the efforts of GCOAT.

Recently, all healthcare providers received an email from GCOAT asking them to complete an online training module covering the new guidelines.

The training module contains the following:

- A 3-question introductory quiz to gauge healthcare providers’ “pre-training” knowledge of the new acute pain opioid prescribing guidelines.
- A 10-minute training video that summarizes the new guidelines.
- A brief conclusion quiz to gauge how healthcare providers plan to adjust their acute opioid prescribing practices.

CDC Releases Guidelines for Prescribing Opioids for Chronic Pain

The Centers for Disease Control and Prevention (CDC) has released the [Guideline for Prescribing Opioids for Chronic Pain Morbidity and Mortality Weekly Report \(MMWR\)](#).

The guideline provides 12 recommendations for primary care clinicians about the appropriate prescribing of opioids to improve pain management and patient safety. It will:

- Help clinicians determine if and when to start prescription opioids for chronic pain;
- Give guidance about medication selection, dose, and duration as well as when and how to reassess progress, and discontinue medication if needed; and
- Help clinicians and patients work together to assess the benefits and risks of prescription opioid use.

CDC has created a [Fact Sheet](#) that anyone can use to promote the guidelines.

These guidelines are similar to those that have been developed in Ohio by the Governor’s Cabinet Opiate Action Team (GCOAT). Those guidelines can be viewed using [this link](#). Click on the box “Opioid Prescribing Guidelines.”

OWPN Releases Resources to Help Community Leaders Address Health Challenges

The AMCNO is a member of the Ohio Wellness and Prevention Network (OWPN), which is part of the Health Policy Institute of Ohio (HPIO). Recently, the OWPN released to its members a [Guide to Evidence-Based Prevention](#) to help community leaders address health challenges identified in the HPIO’s Health Value Dashboard and what works to prevent these health concerns, such as tobacco use and secondhand smoke exposure, food security and healthy food access, and physical activity.

The groups also cited additional resources related to the work they do:

Health and Equity in All Policies

[Health and Equity in All Policies—Ohio Update](#)

OWPN “lunch and learn” webinar, which was held Thursday, June 9

[Embracing equity in community health improvement](#)

Report from Health Resources in Action

Population health

The association between income and life expectancy in the United States, 2001-2014

[Article](#) in the Journal of the American Medical Association (free access available)

[Health Inequality Project website](#)

[Interactive data tool](#) from the New York Times

Variation in health outcomes: The role of spending on social services, public health and health care, 2000-2009

[Article](#) in Health Affairs (subscription required to access full text)

[Article](#) in USA Today (free access available)

[Spotlight: Impact of unhealthy behaviors](#)

State profile reports from America’s Health Rankings

The HIMSS Interoperability Showcase Comes to The HIMSS Innovation Center

The Healthcare Information and Management Systems Society (HIMSS) Interoperability Showcase has brought a booth presence to the HIMSS Innovation Center at the Global Center for Health Innovation in Cleveland to spread the message of the importance of health information exchange.

The booth provides year-round access to content from HIMSS16 and the various HIMSS programs. New content is constantly being added to provide attendees with current and engaging information. Visitors are able to gain unique perspectives on interoperability, through participation from Leadership Sponsors from HIMSS16. Vendors share their experiences at the showcase and information on how they support standards-based interoperability.

Ohio Supreme Court Refines “Medical Records” Definition in *Griffith v. Aultman Hospital*

In *Griffith v. Aultman Hospital*, the Ohio Supreme Court recently reversed the Fifth District Court of Appeals (located in Canton) on the question of what constitutes “medical records” in Ohio, such that they must be produced to a patient upon request. The court of appeals had held that the medical records that must be produced upon request are those that are maintained by the hospital’s medical records department and for which medical providers made a decision to keep or preserve to further the treatment process. The Supreme Court’s ruling preserved part of this standard, but did so in a way that expands the concept of what is a medical record to include all “records” regardless of where in the hospital they are kept, or which department of the hospital keeps the records. This new standard will almost certainly prove cumbersome and may ultimately be unworkable. For example, records kept by risk management departments, multi-disciplinary committees, and by IT departments (including extremely large volumes of electronic records that are never reduced to print) may now be discoverable. Many sophisticated testing procedures can produce thousands and thousands of theoretical “records,” a small fraction of which are relied upon and preserved by medical records departments. Justices Terrence O’Donnell and Judith Lanzinger dissented and would have defined

medical records consistent with the court of appeals. Justice Lanzinger succinctly recognized the practical implications raised by the AMCNO in its amicus brief as follows:

The judgment of treating healthcare providers must be relied upon to determine what is (or is not) part of a patient’s medical record, those providers being best able to determine what information is relevant to a patient’s treatment. Hospitals and other providers have teams of employees dedicated to collecting and maintaining this information, and, as the *amici curiae* have noted, many hospitals have multidisciplinary committees that determine what information should be included in a medical record. The information in the medical record presents the relevant and necessary information that is always subject to being supplemented in the clinical judgment of the treating providers.

The Supreme Court remanded the *Aultman* decision to the trial court to reconsider what must be produced under the facts of that case. The majority decision did recognize “that the term “medical record” in R.C. 3701.74(B) **does not include all patient data but includes only that data that a healthcare provider has decided to keep or preserve** in the process of treatment.” But the opinion is less clear where it states that “[t]he statute defines ‘medical record’ to mean any patient data ‘generated and maintained by a health care provider,’ **without any limitation as to the physical location or department where it is kept.**”

An initiative with the Ohio Legislature to clarify the meaning of R.C. 3701.74 could prove helpful on this issue. No one is looking to prevent patients from having full access to their medical records. But at the same time, hospitals and other medical providers should not be burdened with large-scale additional documental retrieval responsibilities that will be extremely time-consuming but add little substance to questions of whether medical negligence occurred.

For more information on the court’s ruling, [click here](#).

AMA Creates Zika Virus Resource Center

The World Health Organization recently met in Geneva to decide whether the Zika outbreak should be declared a “public health emergency of international concern.” Concurrently, the American Medical Association (AMA) is ensuring that physicians are prepared to respond to patients concerns about this mosquito-transmitted disease.

The AMA has created an online Zika Virus Resource Center as a clearinghouse for timely, credible information from the CDC, other respected health organizations, and *The Journal of the American Medical Association (JAMA)*.

Please visit the AMA's Zika Resource Center at: <http://www.ama-assn.org/go/zika>

Physicians can access this information by visiting the AMA website and clicking on the homepage tile “Zika Virus Resources.” These resources are intended to support physicians to:

- Educate medical teams and inform patients about the risks and symptoms of the Zika virus;
- Detect the Zika virus;
- Treat the symptoms and effects of the virus;
- Remain up-to-date about this infection; and
- Communicate clearly and factually with patients, their families, and the media about exposure risks and potential preventive measures, particularly as new evidence becomes available.

The AMA will continue to monitor developments in this realm and take additional steps as warranted.

ICD-10: Protecting Your Cash Flow

By Tamiya Williams, CMPE, Senior Manager, Medic Management Group, LLC

(This is a reprint of the article that appeared in the *Northern Ohio Physician* magazine.)

For the most part, the transition to ICD-10 went off without a hitch, and most practices feel like claims are processing normally. Practices have put in a lot of up-front work preparing for ICD-10, which has definitely played a big role in the smoothness of the transition. With that being said, there have been some providers who have reported that they are seeing claim denials for screenings such as colonoscopies. Providers have also reported that they have seen a reduction in their productivity due to the extra time being spent on documentation and coding.

Medicare Administrative Contractors (MACs) have been reactive to fixing identified problems and have been very responsive to practice inquiries. The denials that providers are seeing have stemmed from Local Coverage Determination Edits (LCDs) not being properly loaded. In some cases, once the LCD has been properly loaded, claims have been automatically reprocessed by the MACs; this is a big help to the providers because the claims do not have to be resubmitted by the billing staff.

Before the transition to ICD-10, providers were aware that they were going to have to include more information in their documentation, but not to the extent that their productivity would be affected. Providers are not the only ones being impacted; coding professionals are also seeing a decrease in productivity as well, due to the amount of time it is taking to review provider notes to make sure documentation correct and that the proper ICD-10 codes have been added to the claims before submission.

In July of 2015, CMS announced that non-specific ICD-10 codes would be permitted for one year from the ICD-10 transition date (Oct. 1, 2015). Even though CMS has given providers this much-needed grace period, practices should be taking the following steps to ensure cash flow is not delayed in any way.

Make sure that the Practice Management System/Electronic Health Record have the necessary updates needed to transmit claims with ICD-10 codes. Although most software vendors have been taking the necessary steps to be ICD-10 compliant, that doesn't mean that claims will not be denied. If denials are happening, it is important to determine what has caused the denial. The following questions will need to be answered:

- Are the ICD-10 codes on the claim accurate and valid?
- Is all of the patient demographic information on the claim correct?
- Did all of the claim information provided transmit correctly from the Practice Management System to the clearinghouse to the insurance company?

All of the above questions are important when taking a look at the systems in use and/or identifying why a claim denied. When making sure that the technology in use is up to par, the third question is the most important. If a practice finds that claims aren't transmitting properly from the software currently being used, the vendor needs to be contacted immediately. The issue could be a simple or complicated fix for the vendor, but it will allow the practice to implement changes and/or workarounds to prevent future denials until the issues have been corrected by the vendor.

Assess productivity and provide ongoing training for providers and coding staff. It is important to know where the staff stands in regards to productivity. If staff is falling behind, it is important to know why, in what areas, and if there are identifiable reasons. Ultimately, a delay in workflow means a delay in cash flow.

Productivity delays can easily be corrected by providing things such as: training in the area specific to the specialty, implementing the use of templates, implementing the use of electronic coding software, and utilizing outside coding vendors and staff on a temporary basis. It is also important to remember that training should be ongoing in every practice so everyone is kept up to date on changes and new information.

Conduct ongoing coding/documentation audits and closely monitor denials. It is important for the practice to be aware of the types of claims being submitted to the insurance companies and the types of denials be received. Knowing what claims are being denied will allow a practice to focus on specific claim types and correct issues prior to claims submission. Knowing what claims are being denied will also provide a platform for training all staff. When a practice is aware of the certain types of claims being denied, the billing staff will know what claims to keep an eye to make sure that there isn't a delay in the processing of the claim for payment.

As we quickly approach Oct. 1, 2016, providers need to make sure that their documentation is in compliance with all of the ICD-10 requirements to prevent denials from insurance payers. A good training method is to take a providers' top 20 ICD-10 codes and claim types (office visit, procedure, screening, etc.) and make sure that the documentation is in line with the requirements set forth by CMS.

It is also important to remember that even though CMS has given providers a break on documentation and coding to the highest specificity, by not denying claims solely for that reason, the end of the transitional period will be here before we know it. Providers should keep the lines of communication open with all support staff (clinical, clerical, billing, and coding) to make sure everyone is on the same page about what is required in order for a claim to be considered "clean" prior to submission. A "clean" claim means that everything, including patient demographics, insurance information, CPT codes, ICD-10 codes, and documentation, are all in order prior to submission to the insurance company. Using this transition period to educate providers and support staff will help prevent any future delays in cash flow.

MACRA – What Is It and What You Can Do Now to Prepare

By Tamiya Williams, CMPE, and LaDonna Kessler, Senior Managers at Medic Management Group, LLC

On April 16, 2015, the Medicare Access and CHIP Re-Authorization Act (MACRA) of 2015 was signed into law, permanently repealing the Sustainable Growth Rate (SGR) formula and imposing a new payment methodology for Medicare Part B payments starting in 2019 (reflected from performance year 2017). Transitioning from Fee for Service (FFS) to a Quality Payment Program creates two new payment tracks:

- The Merit-Based Incentive Payments System (MIPS)
- Advanced Alternative Payment Models (APMS)
 - Initial Performance Period will be January 2017 – December 2017

In April 2016, CMS released the proposed rule outlining how it plans to implement the Medicare payment changes stipulated in the law. CMS solicited public comment on this proposal until June 27, 2016, and Eligible Clinicians (EC) were encouraged to participate.

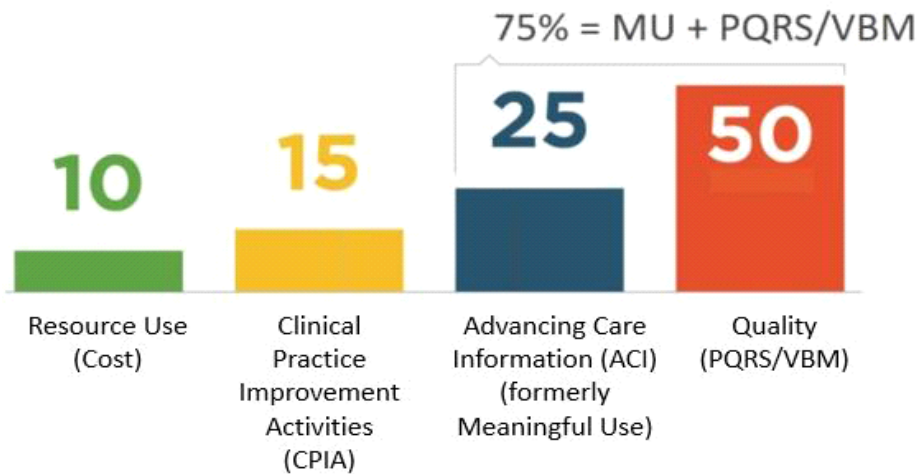
The Merit-Based Incentive Payment System (MIPS)

Medicare currently measures the value and quality of care provided by physicians and other clinicians through a conglomerate of programs, including the Physician Quality Reporting System (PQRS), the Value-Based Modifier Program, and Meaningful Use. Congress streamlined these programs into one new Merit-Based Incentive Payment System (MIPS). MIPS reduces the number of measures clinicians are required to report on in some categories and allows clinicians the flexibility to select from a set of measure to report on based on the relevancy to their practice.

Eligible Clinicians Under MIPS

- Years 1 and 2 (2017 and 2018)
 - Physicians – MD/DO and DMD/DDS
 - Physician Assistants
 - Nurse Practitioners
 - Clinical Nurse Specialists
 - Certified Registered Nurse Anesthetists
- Years 3+ Secretary may broaden ECs to include others
- Although most clinicians will participate in MIPS, there are some that will not qualify. They are:
 - Clinicians who are in their first year of Medicare Part B participation
 - Medicare ECs who have billed charges less than or equal to \$10,000 **and** who provide care for 100 or fewer Medicare patients in one year
 - Certain participants in ADVANCED Alternative Payment Models
 - MIPS does not apply to hospitals or other facilities

MIPS allows Medicare clinicians to be paid for providing high-quality, efficient care through success in four performance categories:



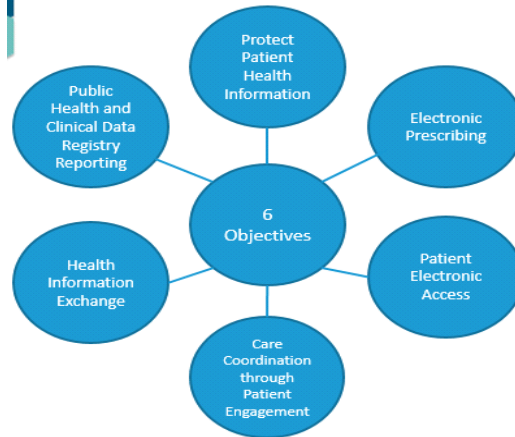
Quality

The Quality category counts as 50% of the total score in 2017. This category also replaces the current PQRS and Value-Based Modifier programs. Clinicians will need to report on six measures versus the nine measures that they are required to report on under the current PQRS guidelines. This category will also give clinicians reporting options to choose from to accommodate differences in specialties and practices. Clinicians will still be required to report on at least one cross-cutting measure and one outcome measure. If an outcome measure is not available, then the clinician would report on one other high-priority measure in lieu of an outcomes measure.

Advancing Care

The Advancing Care Information (ACI) category counts as 25% of the total score in 2017. This category replaces the Medicare EHR Incentive Program (Meaningful Use or MU). Clinicians will be required to report on customizable measures that reflect how they use EHR technology in day-to-day practices, with a particular

emphasis on interoperability and information exchange. ACI requires clinicians to report on fewer objectives than the original MU requirements. Keep in mind that the Medicaid MU and Hospital MU programs are unaffected. The six proposed ACI Objectives are as follows:

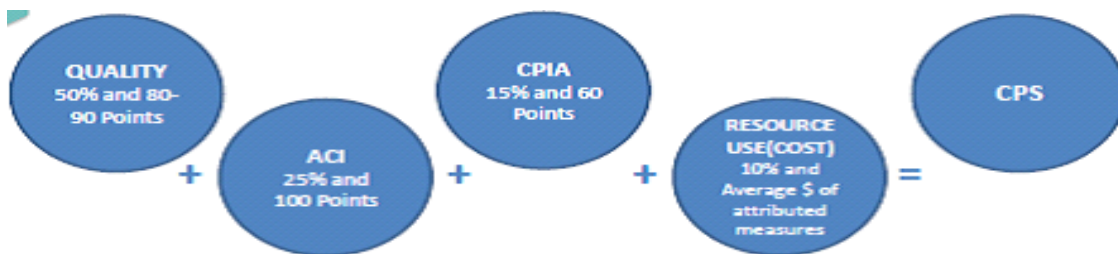


Clinical Practice Improvement Activities

The Clinical Practice Improvement Activities (CPIA) category counts as 15% of the total score in 2017. Clinicians can select activities that match their practice goals from a list of more than 90 options. At minimum, clinicians must select one activity to implement. Bonus credit will be earned for additional activities. If a practice has earned a designation of Patient-Centered Medical Home (PCMH), full credit in the CPIA category will be earned. Clinicians who are participating in an Advanced Payment Model (APM) will earn half credit for the CPIA category.

Resource Use/Cost

The Resource Use/Cost category counts as 10% of the total score in 2017. Resource Use, also known as Cost, replaces the Value-Based Modifier Program. CMS will calculate this score based on Medicare claims and availability of sufficient volume, meaning no reporting requirements for clinicians. This category will use more than 40 episode-specific measures to account for differences among specialties.



The Cost Performance Score (CPS) will be used to determine whether a MIPS EC receives an upward payment adjustment, no payment adjustment, or a downward payment adjustment. All payment adjustments will be scaled for budget neutrality as required by the statute. The CPS will also be used to determine whether a MIPS EC qualifies for an additional positive adjustment factor for exceptional performance.

Advanced Alternative Payment Models (APMs) “Pre-Approved” by CMS

CMS is continuously taking the steps needed to attain care transformation with the development and approval of the following Advanced Alternative Payment Models:

- Medicare Shared Savings Program – Track 2 or Track 3

- Next Generation ACO Model
- Comprehensive ESRD Care Model (large dialysis organization arrangement)
- Comprehensive Primary Care Plus (CPC+1)
- Oncology Care Model Two-Sided Risk Arrangement (2018)

APM track participants will be exempt from MIPS payment adjustments and would qualify for a 5% Medicare Part B incentive payment in 2019-2024.

What Can Be Done Now to Prepare

It is very important that preparation for MACRA starts now. The final rule is expected to be released by CMS in November 2016. Some of the key components to success are as follows:

- Educate your organization on MACRA
- If your practice does not have an EHR, it is important to implement one
- Make sure you are successfully participating in PQRS
- Make sure you are successfully participating in MU
- You must complete a Security Risk Analysis
- Monitor Quality Reporting Dashboards on a regular basis to identify deficiencies

Remember, MU and PQRS as we know it will end on Dec. 31, 2016, and MACRA will take effect Jan. 1, 2017. Be on the lookout for the final rule coming later this year.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

The AMCNO Practice Management Matters newsletter includes items that have been published by Medicare and other third-party payers online or in their newsletter and may contain links that provide direct access to Internet sites other than our own. The AMCNO takes no responsibility for the content or the information obtained on other websites, as we do not have any editorial control over those sites. Additional information on these topics may be available on our website at www.amcno.org

6100 Oak Tree Blvd. Suite 440 Independence, OH 44131

www.amcno.org

216.520.1000 Executive Offices 216.520.0999 Facsimile