MACRA, MIPS & APMS

DR. ELISABETH VOLPERT DNP, APRN, FNP-C

FIRST THING IS FIRST

• I Have No Disclosures

OBJECTIVES

• Explain the definition and purpose of value-based reimbursement:
  • The Medicare Access and CHIP Reauthorization Act (MACRA)
  • Merit-Based Incentive Payments System (MIPS)
  • Alternative payment models (APMs)
• Explain who value-based reimbursement applies to.
• Explain the 2019 updates.
• Explain how to increase reimbursement by meeting benchmarks.
• Explain alternative office visits that can increase reimbursement, improve outcomes and achieve benchmarks.

TERMS

• APM – Alternative payment models
• CMS – Centers for Medicare and Medicaid Services
• EHR – Electronic Health Record
• MACRA - Medicare Access and CHIP Reauthorization Act
• MIPS - Merit-Based Incentive Payments System
• MU – Meaningful Use
• PQRS – Physician Quality Reporting System
• QP – Qualifying APM Participant
• SGR – Sustainable Growth Rate
• VM – Value-Based Payment Modifier

A STROLL DOWN MEMORY LANE

• Late 1950s: 75% Americans had private insurance
  • AMA was against national health insurance
• 1965 Medicare Part A & B
  • Fear physicians would decline to see pt with this coverage
  • Development of fee for service
• 1973 HMO
  • Fee for service, increase procedures and decrease preventative care
• 1997 Sustainable Growth Rate (SGR)
• Restrict Medicare Part B
• April 16, 2015 MACRA
• CMS: named the physician payment system created by MACRA the Quality Payments Program (QPP)

CMS’ Program History


A STROLL DOWN MEMORY LANE

• 2015: The Medicare Access and CHIP Reauthorization Act terminated the Sustainable Growth Rate (SGR) formula.
  • If SGR would have continued it would have resulted in significant payment reductions for clinicians participating in Medicare.

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA)

• The Department of Health & Human Services established a goal to convert from fee-for-service Medicare payments to value-based payment models.
  • A form of reimbursement that links payments for care to the quality of care provided.
  • Incentivizes providers with rewards for both efficiency and effectiveness of care.

MACRA’s Goal

• CMS Center for Clinical Standards and Quality Director, Kate Goodrich, MD, stated MACRA’s goal:
  “To have a single, unified program with flexibility. The new Merit-Based Incentive Payment System (MIPS) will offer that flexibility and not be a one-size fits all program. The new rule will reimburse physicians based on four factors.”

MACRA GOALS

• Improve patient outcomes and reduce overall costs the healthcare system.
  • Expect in 2019 to:
    • Reduce administrative costs by $87 million
    • $843 million over the next 10 years
    • Save 21 million clinician hours

WHO CAN PARTICIPATE IN QUALITY PAYMENT PROGRAMS

• Nurse Practitioners
• Some Physicians
• Physician Assistants
• Clinical Nurse Specialist
• Certified Registered Nurse Anesthetists
• Physical Therapist
• Occupational Therapist
• Speech Therapist
• Audiologist
• Clinical Psychologist
• Registered Dietitian or Nutritional Professional
WHO IS IN

Bill more than $90,000 a year in allowed charges for covered professional services.

Provide care to 200 or fewer Medicare beneficiaries a year

Provide 200 or fewer covered professional services under the PFS

Low-volume threshold criteria.

WHO IS OUT

- If you do not exceed all three you are excluded from MIPS.
  - You have the opportunity to "opt-in" if you meet or exceed one or two of the low-volume threshold criteria.

AM I IN OR OUT?

- To verify if you’re eligible to participate in MIPS, enter your 10-digit National Provider Identifier in the status tool at:
  
  https://qpp.cms.gov/participation-lookup

4 MIPS AREAS

- Quality (45%)
- Promoting Interoperability (25%)
- Cost (15%)
- Improvement activities (15%)

MIPS PERFORMANCE MEASURES

- Quality:
  - 6 measures to submit
  - Example: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
  - 12 months
- Promoting Interoperability:
  - Example: Electronic prescribing, MU
  - 90 days
- Cost:
  - No submission required
  - 12 months
- Clinical practice improvement activities
  - Example: Care coordination
  - 90 days
QUALITY MEASURES

- Quality Payment Program website
  https://qpp.cms.gov/mips/explore-measures/quality-measures
- Changes for 2019
  - 8 new quality measures
  - 26 measures removed

MIPS REPORTING

- January 1, 2019 to December 31, 2019
  - Submit March 31, 2020
  - Feedback July 2020
  - Adjustment January 1, 2021

SCORE

0-----10-----20-----30-----40-----50-----60-----70-----80-----90-----100

78.72

HOW MUCH IS PAYMENT ADJUSTED

- 2019 +/- 4%
- 2020 +/- 5%
- 2021 +/- 7%
- 2022 +/- 9%

APM

- Another payment model to replace fee-for-service
  - Larger organizations - have the infrastructure and resources to implement change
  - To qualify as an eligible Advanced APM,
    - Use of certified EHR technology
    - Base payment must be based on quality measures (comparable to MIPS)
    - There also needs to be financial risk
      - or operate as a medical home (meeting CMS criteria)

QUALIFYING APM PARTICIPANTS

- Clinicians meeting the criteria for this track are excluded from MIPS.
  - Receive a lump sum bonus payment of 5% 2019-2024
  - Receive a high fee schedule
PARTIAL QUALIFYING APM PARTICIPANTS
• Meet a reduced threshold
• Participants can choose whether or not to participate in MIPS

WHO IS IN FOR APMS
• Organizations that are automatically qualified to APMs:
  - Comprehensive ESRD Care Model
  - Medicare Shared Savings Program - Track 2 and 3
  - Next Generation ACO Model
  - Comprehensive Primary Care Plus (PC-P)
  - Oncology Care Model Two-Sided Risk Arrangement

SUMMING UP SO FAR
• MACRA
• MIPS vs. APM
• More types of clinicians will need to report
• Opt-in and opt-out
• New measures
• Increase in penalties for clinicians who do not report or fail to meet minimum threshold (30 points)
• Increase payment adjustments

SO WHY?

WHAT IS NEXT
• New Value-Based Bundled Payment Model
  • Announced in January 2018, and will be from October 1, 2018 through December 31, 2023.
  • Participants can earn additional payments
    • Bundled payments for additional clinical episodes
    • Additional episodes
    • Posthospitalary target prices:
      • CMS will pay for episodes of care under the model
      • Participants assume risk for patients’ healthcare costs
      • If all expenditures for a beneficiary’s episode of care are less than a spending target
      • If the expenditures exceed the target price, the participant must repay money to Medicare

HOW DO I SUCCEED

IMPROVED HEALTH OUTCOMES

KEEP CALM AND NURSE ON
HOW CAN WE IMPROVE OUTCOMES

• Controlled High Blood pressure
  - Proper assessment
  - Logs
  - Shorter follow-up

• Hemoglobin A1C Control (<9%)
  - Chart audit
  - Shorter follow-up
  - Portal or telephone messages

HOW CAN WE IMPROVE OUTCOMES

• Colorectal Cancer Screening & Breast Cancer Screening
  - Chart audit
  - Cologuard and FIT
  - Permanent deferral

• Influenza Immunization & Pneumonia Vaccination
  - Chart audit
  - Patient immunization cards in exam rooms
  - Permanent deferral

HOW CAN WE IMPROVE OUTCOMES

• Diabetic Eye Exam
• Falls Screening
• BMI Screening and Follow-Up

HOW MANY CLICKS ARE TOO MANY?

“I hear there’s a new ICD-10 code for carpal tunnel syndrome caused by clicking too many times in an EMR system.”
DOES IT REALLY MATTER?

- Payment is there!
- Linked to NPI

REFERENCES