MACRA's Quality Payment Program:

What Does it Mean for Your Agency's Medicare Reimbursement?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) makes sweeping reforms to payments under Medicare Part B, which could decrease or increase the amount your agency is reimbursed by Medicare. The Centers for Medicare and Medicaid Services' (CMS) Quality Payment Program has two parts: the **Merit-based Incentive Payment System (MIPS)** and the **Advanced Alternative Payment Models (Advanced APMs)**. Both mechanisms focus on moving from payment for volume to payment for quality and value, and non-participation will result in reductions in reimbursement. It is anticipated that **the vast majority of behavioral health organizations that bill Medicare Part B will be subject to MIPS** in 2017. CMS is currently reviewing public comments on their proposed rules for the program, and is expected to issue a final rule in November 2016.

MIPS ESSENTIALS

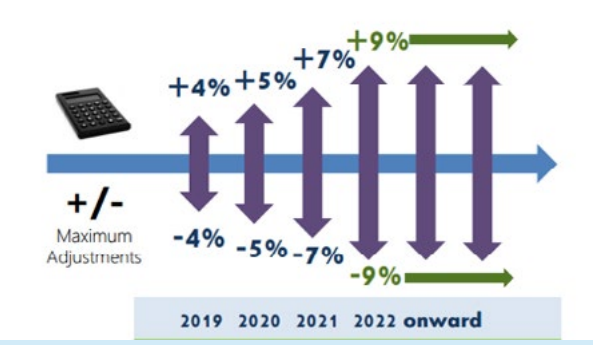
MIPS collapses three existing quality reporting programs into one, while adding a fourth category:

- The **Physician Quality Reporting System** (PQRS) becomes **Quality** under MIPS, and requires eligible clinicians to report certain quality measures on an annual basis.
- The **Value-based Payment Modifier Program** (VM) becomes **Resource Use** under MIPS, and compares costs to treat similar care episodes and clinical condition groups across practices.
- The **Medicare Electronic Health Record** (EHR) incentive program becomes **Advancing Care Information** under MIPS, and retains an emphasis on interoperability and information exchange.
- A brand-new reporting area is **Clinical Practice Improvement Activities** (CPIA), which rewards practices that engage in quality improvement activities, including for their Medicaid and other non-Medicare patient populations.

Scoring. Each of the four categories listed above is weighted and collectively form a composite performance score (CPS) on a scale from 0-100. The CPS will be used to compare practices and determine payment adjustments. Category weights may be redistributed if a clinician or group cannot report in a certain category. Performance category weights are expected to change over time.

MIPS Eligible Clinicians. Clinicians that will be counted for the 2017 reporting year include physicians (including psychiatrists), nurse practitioners, physician assistants, clinical nurse specialists and certified registered nurse anesthetists. Social workers and clinical psychologists may be added in 2019.

Maximum and Minimum MIPS Payment Adjustments. Based on 2017 calendar year reporting, MIPS eligible clinicians will receive up to a 4 percent payment adjustment in 2019. Adjustments may be positive, negative or zero. The range of payment adjustments will reach +/- 9 percent by 2022. Clinicians may earn an extra bonus of up to 10 percent for exceptional quality from 2019 to 2024. All MIPS adjustments are **budget neutral**, which means that total upward and downward adjustments will be equal.



PERFORMANCE CATEGORIES UNDER MIPS

Quality

An adaptation of the PQRS program, the Quality category requires clinicians to choose six measures to report that best reflect their practice (as opposed to nine under PQRS). Clinicians may report measures from the Mental/Behavioral Health Specialty Set to fulfill this requirement. Like PQRS, MIPS provides a very limited number of behavioral health-related quality measures. Quality measures will be selected annually through a call for quality measures process. CMS will publish a final list of quality measures in the Federal Register by **November 1** of each year. If a clinician/group does not have a sufficient sample size to report on six quality measures, there is no penalty. If a clinician/group can only report on fewer than six measures, CMS will reduce the weight of the Quality category and reassign the missing weight proportionally to other categories.

Advancing Care Information

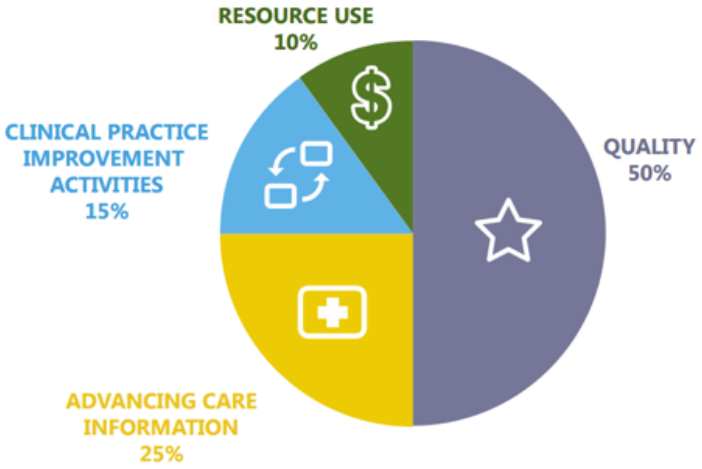
An adaptation of the Medicare EHR incentive program, this category requires MIPS eligible clinicians to use certified EHR technology (CEHRT). Clinicians can choose to report a customizable set of measures that reflect how they use this technology in day-to-day practice, with emphasis on protecting patient health information, patient electronic access, coordination of care, electronic prescribing, health information exchange and public health and clinical data registry reporting. Since some MIPS eligible clinicians may not be able to report on Advancing Care Information measures, CMS may decide to not score this category at all, and redistribute the category's weight to other categories to make up the difference.

Clinical Practice Improvement Activities

This new category enables clinicians to choose from a list of more than 90 activities, and determine which ones best suit their practice. Examples of activities on the current list include primary-behavioral health care integration, care coordination and expanding access to care, use of condition-specific pathways of care for chronic conditions such as depression and provision of peer-led support for self-management.

Resource Use

An adaptation of the Value-based Modifier payment program, this category compares one provider's Medicare Part B charges for a diagnostic group or episode of care against other providers' charges. There are no behavioral health-related categories in the April 2016 proposed rule. A clinician or group practice's Resource Use score is based on a CMS claims analysis and does not require independent reporting. If an individual clinician or group cannot report in this category and reports on at least three quality measures, the Resource Use weight will be added to the Quality category (60 percent).



How to Report

- MIPS eligible clinicians must collect and report data for Quality, Advancing Care Information and CPIA performance categories.
- Clinicians may report as an individual or as part of a group. How you choose to report determines the reporting mechanisms you can use (see table below).
- Under MIPS, groups will be defined as two or more MIPS eligible clinicians as identified by their individual National Provider Identifier (NPI), who bill using a single Taxpayer Identification Number (TIN).
- MIPS eligible clinicians reporting as individuals will report using a combination of their billing TIN/NPI. Each unique TIN/NPI combination will be considered a different MIPS eligible clinician, and MIPS performance will be assessed separately for each TIN under which an individual clinician bills.
- Individuals and groups may use multiple reporting mechanisms, but they must use the same identifier for all performance categories and may only use one submission mechanism per category.
- MIPS data may be reported through third party vendors, such as qualified clinical data registries (QCDRs), health IT vendors that obtain data from CEHRT, or a CMS-approved survey vendors.
- Data submission is due for all reporting methods across all MIPS performance categories by March 31 following the performance year, which spans January 1-December 31.

Performance Category	Mechanisms to Report as an Individual	Mechanisms to Report as a Group
Quality	• Claims • QCDR • Qualified registry • EHR • Administrative claims (no submission required)	• QCDR • Qualified registry • EHR • CMS Web Interface (groups of 25 or more) • CMS-approved survey vendor for Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS (must be reported in conjunction with another data submission mechanism) • Administrative claims (no submission required)
Advancing Care Information	• Attestation • QCDR • Qualified registry • EHR	• Attestation • QCDR • Qualified registry • EHR • CMS Web Interface (groups of 25 or more)
Clinical Practice Improvement Activities	• Attestation • QCDR • Qualified registry • EHR • Administrative claims (if technically feasible, no submission required)	• Attestation • QCDR • Qualified registry • EHR • CMS Web Interface (groups of 25 or more) • Administrative claims (if technically feasible, no submission required)

What You Should Do to Prepare for MIPS

Start NOW. 2019 payment adjustments will be based on 2017 performance.

Determine MIPS eligibility. Is your organization below the low-volume threshold of seeing fewer than 100 Medicare patients and billing Medicare less than $10,000 per year? Is 2017 your first year billing Medicare? Are you a federally qualified health center (FQHC), hospital or facility? If the answer is yes, MIPS does not apply to you in 2017.

Familiarize yourself with current quality reporting programs. The PQRS, Meaningful Use and the Value-based Modifier programs are not going away! Understand how current quality reporting programs work now and participate if possible--you'll be better prepared when the MIPS reporting year starts on January 1, 2017.

Educate your team. Make sure that your staff and leadership understand MIPS, how it will measure performance and how it may affect Medicare reimbursements starting in 2019.

Explore National Council learning community opportunities and other technical resources at www.thenationalcouncil.org

Familiarize yourself with MIPS behavioral health-related quality measures. Which quality measures best suit your clinical practice? Check these measures against measures for other quality program initiatives to maximize efficiency and performance levels.

Familiarize yourself with the CPIA activities. Determine which quality improvement activities you are already doing, and what steps you might need to take to maximize your CPIA score in 2017.

Connect with the CMS-funded Transforming Clinical Practice Initiative (TCPI). TCPI supports 29 Practice Transformation Networks (PTNs) and Support and Alignment Networks (SANs) across the country, which provide resources and technical support to help practices improve quality of care, reduce costs and prepare for value-based payment arrangements. Visit www.healthcarecommunities.org or contact the National Council to learn more.

If you have an EHR, make sure it is certified EHR technology (CEHRT). A well-designed CEHRT can help you fulfill current quality reporting requirements and provide real-time summaries of your progress on quality measures. If you have an EHR, determine whether it is 2014- or 2015-edition certified — the version will determine your reporting measures in 2017.

If you don't have an EHR, use a clinical data registry. Clinical data registries can streamline reporting, help identify high-risk populations and improve clinical practice.

Learn as much about the Quality Payment Program as you can — even if MIPS does not apply to you. Value-based payments are an important goal for all the major payers, not just Medicare. To meet these demands, all behavioral health organizations will need to cultivate an organizational culture that embraces change, and develop the infrastructure needed to measure progress, demonstrate value and improve health outcomes.

Stay up-to-date. CMS will release the final rule in November, but will likely update requirements on an annual basis. The National Council will help you stay informed so you can meet your requirements every year. Subscribe to the National Council's **Capitol Connector blog**, register for our **MACRA webinar series** and check the National Council website for MACRA resources.

Behavioral Health-related Quality Measures

- Anti-depressant medication management
- Preventive care and screening: screening for clinical depression and follow-up plan
- Elder maltreatment screen and follow-up plan
- Dementia: cognitive assessment
- Dementia: functional status assessment
- Dementia: neuropsychiatric symptom assessment
- Dementia: management of neuropsychiatric symptoms
- Dementia: counseling regarding safety concerns
- Dementia: caregiver education and support
- Adult major depressive disorder (MDD): coordination of care of patients with specific comorbid conditions
- Adherence to antipsychotic medications for individuals with schizophrenia
- Follow-up after hospitalization for mental illness

In 2017, MIPS does NOT apply to:

- Clinical psychologists and licensed clinical social workers (this may change in 2019)
- First-year Medicare providers
- Qualifying advanced APM clinicians
- Hospitals and facilities
- Providers who fall beneath CMS's low-volume threshold, who serve fewer than 100 Medicare recipients and bill Medicare less than $10,000 per year
- Clinicians and groups who are not paid under the Physician Fee Schedule (e.g., FQHCs and partial hospitalization programs)

ADDITIONAL RESOURCES

MACRA proposed rule

CMS overview of the quality payment program

Register for the National Council's three-part MACRA webinar series in August 2016

QUESTIONS?

www.TheNationalCouncil.org

Contact: Elizabeth Arend at ElizabethA@TheNationalCouncil.org

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