

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 lower 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 payment for quality and efficiency of care, and non-participation will result in significant 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 2018.

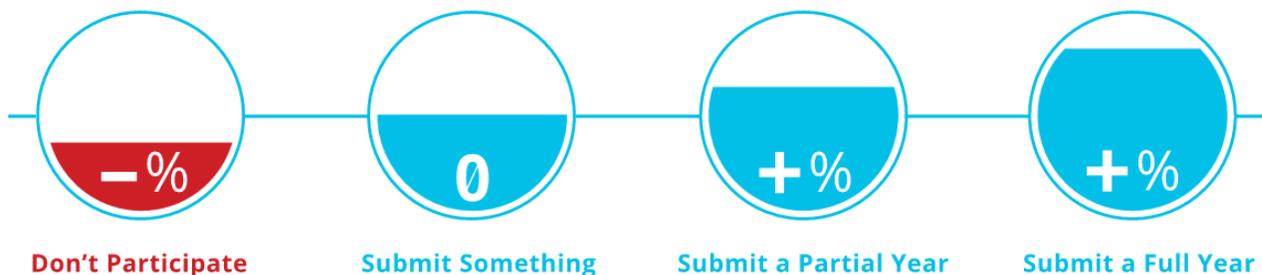
MIPS ESSENTIALS

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 assesses eligible clinicians on their performance on at least six quality measures on an annual basis.
- The [Value-based Payment Modifier Program \(VM\)](#) becomes **Cost** 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 new reporting area is **Improvement Activities**, which rewards practices that engage in quality improvement activities, including for their Medicaid and other non-Medicare patient populations.

MIPS-Eligible Clinicians. Clinicians that will be counted for performance Year 2 (2018) include physicians (including psychiatrists), nurse practitioners, physician assistants, clinical nurse specialists and nurse anesthetists. Social workers and clinical psychologists may be added in 2019, and may voluntarily report to MIPS in 2018 without impacting their reimbursement in 2020.

Scoring and Payment Adjustments. Each of the four categories listed above are weighted and collectively form a final score on a scale from 0-100. CMS will compare the final score to a performance threshold and determine whether a clinician or group will receive a positive, neutral or negative payment adjustment. In 2018, the performance threshold is 15/100 points, which will enable the majority of participating clinicians to avoid a negative payment adjustment in 2020.



Transition Year 1 (2017) Final

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%



Year 2 (2018) Final

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

How can I achieve 15 points?

- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.

Transition Year 1 (2017) Final

Final Score 2017	Payment Adjustment 2019
≥70 points	<ul style="list-style-type: none"> • Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	<ul style="list-style-type: none"> • Positive adjustment • Not eligible for exceptional performance bonus
3 points	<ul style="list-style-type: none"> • Neutral payment adjustment
0 points	<ul style="list-style-type: none"> • Negative payment adjustment of -4% • 0 points = does not participate

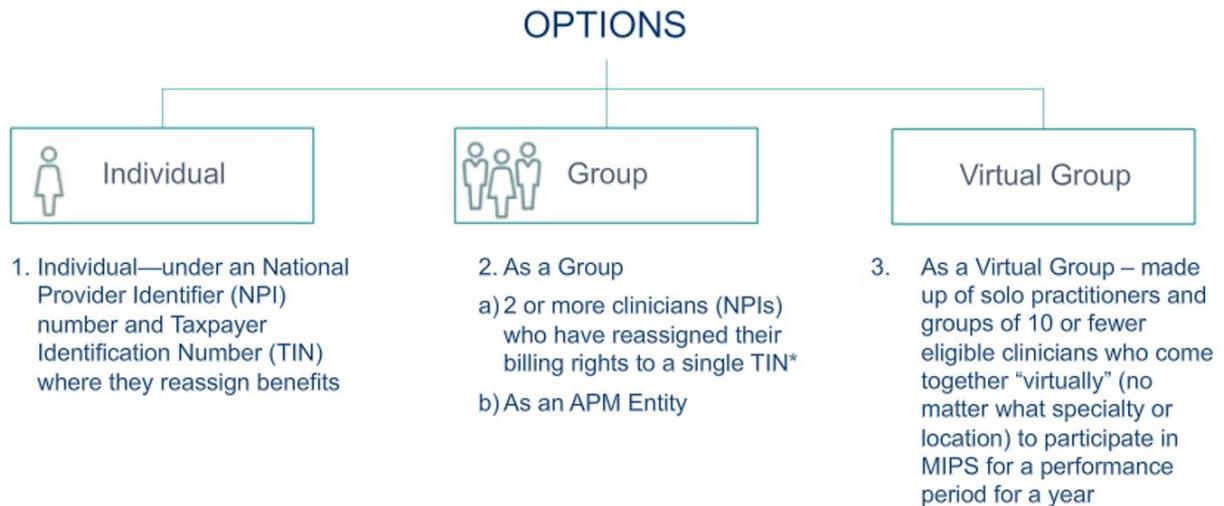


Year 2 (2018) Final

Final Score 2018	Change Y/N	Payment Adjustment 2020
≥70 points	N	<ul style="list-style-type: none"> • Positive adjustment greater than 0% • Eligible for exceptional performance bonus—minimum of additional 0.5%
15.01-69.99 points	Y	<ul style="list-style-type: none"> • Positive adjustment greater than 0% • Not eligible for exceptional performance bonus
15 points	Y	<ul style="list-style-type: none"> • Neutral payment adjustment
3.76-14.99	Y	<ul style="list-style-type: none"> • Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	Y	<ul style="list-style-type: none"> • Negative payment adjustment of -5%

MIPS Reporting Options

The first payment adjustments based on Year 1 (2017) performance will go into effect on January 1, 2019. The provisions of the Year 2 (2018) final rule became effective on January 1, 2018. Performance Year 2 includes the 2018 performance period and the 2020 MIPS payment year. If you choose the MIPS path of the Quality Payment Program, you have three options:



* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.

2018 MIPS PERFORMANCE CATEGORIES

Quality (50%): 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 six out of the 25 measures available in the Mental/Behavioral Health Specialty Set to fulfill this requirement. Quality measures will be selected annually through a call for quality measures process. Additional information about 2018 measures can be found here: [2018 Resources](#)

Cost (10%): 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. A clinician or group practice's Cost score is based on a CMS claims analysis and does not require independent reporting.

Advancing Care Information (25%): 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 an emphasis 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, they may request an exemption. If CMS grants this exemption, it will redistribute the category's weight to the Quality category to make up the difference.

Improvement Activities (15%) This new category enables clinicians to choose from a list of 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.

How to Report

Reporting as an Individual: If an eligible clinician decides to report MIPS data as an individual, his or her payment adjustment will be based on individual performance. An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number (TIN). Eligible clinicians who report as an individual will send their data for each of the MIPS categories through an electronic health record, registry, or a qualified clinical data registry. They may also submit quality data through the routine Medicare claims process.

Reporting as a Group: A group is defined as a set of clinicians (identified by their NPIs) sharing a common TIN, no matter the specialty or practice site. The group will submit 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. The group will receive one payment adjustment based on the group's performance.

Reporting as a Virtual Group: A Virtual Group is a combination of two or more TINs made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter specialty or location) to participate in MIPS for a performance period of a year. A solo practitioner or group can only participate in one virtual group during a performance period. Virtual groups participate in MIPS across all four performance categories, and are subject to the same measure and performance category requirements as other groups reporting under MIPS. Virtual groups can submit data the same ways groups can. Each virtual group would aggregate its data across its TINs for each performance category and be assessed and scored at the virtual group level.

What You Should Do to Prepare for MIPS

- **Determine MIPS eligibility.** Is your organization below the low-volume threshold of seeing fewer than 200 Medicare patients **AND** billing Medicare less than \$90,000 per year? Is 2018 your first year billing Medicare? Are you an FQHC, hospital or facility? If the answer is yes, MIPS does not apply to you in 2018.
- **If you participate in PQRS, Review Your Performance.** What type of feedback have you received on your prior performance? (If you have not already received feedback via your Quality and Resource Use Report (QRUR), refer to CMS guidance [here](#)). What can you do to improve your performance in 2018?
- **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 2020.

- **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 Improvement Activities.** Determine which improvement activities you are already doing, and what steps you might need to take to maximize your score in this performance category in 2018.
- **Connect with the CMS-funded Transforming Clinical Practice Initiative (TCPI).** TCPI supports 29 Practice Transformation Networks and Support and Alignment Networks across the country, which provide free resources and technical support to help practices improve quality of care, reduce costs, and prepare for value-based payment arrangements. Visit <http://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 which measure set you will use to report in 2018.
- **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 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](#) and check out our website's MACRA resources.

Text box 1:

In 2018, MIPS does NOT apply to:

- Clinical psychologists & 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 200 Medicare recipients **AND** bill Medicare less than \$90,000 per year.
- Clinicians and groups who are not paid under the Physician Fee Schedule (e.g., FQHCs and partial hospitalization programs)

Text box 2:

Additional Resources

- [National Council MACRA webpage](#)
- [CMS Year 2 \(2018\) Final Rule Executive Summary](#)
- CMS [Quality Payment Program Online Portal](#)

Text box 3:

Questions?

www.TheNationalCouncil.org

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