SATINSKY CONSULTING

LATE SUMMER 2017 NEWSLETTER

The passage of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 replaced the flawed sustainable Growth Rate formula and accelerated the conversion of Medicare Part B clinician payments from fee-for-service to a value-based payment system. The law was the first step in changing reimbursement not only for Medicare patients, but also eventually for all patients. Our Late Fall 2016 Newsletter and Early Summer 2017 Newsletter contain background information and details on 2017, the transition year.

Margie Satinsky

MACRA QUALITY PAYMENT PROGRAM (QPP) – PROPOSED 2018 CHANGES

MACRA went into effect on January 1, 2017. Although CMS regards the requirements of the 2017 transition year as minimal, one part of the program, the Quality Payment Program (QPP), has generated many questions and concerns from small, independent and rural practices. In response to these concerns, on June 20, 2017 CMS issued a Proposed Rule that would make changes to the QPP in its second year, 2018. Comments are due back to CMS no later than August 18, 2017. This Newsletter identifies and explains ten of the most important proposed changes, focusing on the Merit-based Incentive Payment System (MIPS) track. For a complete explanation of the proposed changes to both the MIPS and Advanced Alternative Payment Models (APMs) tracks, check the resources listed at the end of the newsletter.

The Proposed 2018 Rule for the Quality Payment Program both amends some of the existing requirements and contains new policies for physicians and other clinicians who are participating in QPP in either the Advanced Alternative Payment Models (APM) or Merit-based Incentive Payment System (MIPS) tracks.

CMS worked diligently to solicit stakeholder input prior to proposing the 2018 changes. It engaged more than 100 organizations and over 47,000 people to raise awareness, solicit feedback and assist in clinician participation. By issuing the proposed rule for QPP in 2018, CMS hopes to continue this process of gathering meaningful input, particularly with respect to reducing the administrative burden for clinicians and offering flexibility. These are the highlights of the proposed changes:

1. **New Participation Option:** A new Virtual Groups participation option would give solo groups (i.e. solo practitioners and groups of 10 or fewer eligible clinicians) the option of coming together “virtually” in order to participate in MIPS for a year. Solo practitioners that wish to join a Virtual Group must meet the definition of MIPS eligible. A group that wishes to join a Virtual Group may include eligible clinicians that do not qualify as MIPS eligible. All eligible clinicians in groups that choose the Virtual Group option must participate, and the participation decision to choose this option must be made prior to the 2018 performance period.

2. **Easier Low Threshold Exemption:** An increase in the 2017 low volume threshold from less than or equal to $30,000 or 100 patients to less than or equal to $90,000 or 200 patients would enable more small practices and eligible clinicians in rural and Health Professional Shortage Areas (HPSAs) to be exempt from MIPS participation.
3. **Facility-based Measurement:** The transitional 2017 year has no provisions for facility-based measurement. The proposed change would implement an optional voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program. The option would be available only for facility-based clinicians who have at least 75% of their covered professional services supplied in the inpatient hospital or ER setting.
4. **New Hardship Category under Advancing Care Information (ACI):** In recognition of the special circumstances of small practices, CMS has proposed adding a new hardship category for clinicians in small practices under the Advancing Care Information (i.e. the new name for Meaningful Use) performance category.
5. **More Options for Submission by MIPS Eligible Clinicians:** Moving away from the requirement in 2017 for one submission mechanism per performance category, the proposed rule would allow MIPS eligible clinicians and groups to submit measures and activities through multiple submission mechanisms within a performance category as available and applicable to meet the requirements of the Quality, Improvement Activities, or Advancing Care Information performance categories.
6. **Options for Reporting in the ACI Category:** With respect to Certified Electronic Health Record Technology (CEHRT), eligible clinicians would have the option of continuing the use of 2014 Edition Certified Electronic Health Record Technology (CEHRT) or using the 2015 Edition CEHRT. There's an exception for eligible clinicians for which the EHR was decertified, retroactively effective to performance periods in 2017.
7. **Time Frame for Reporting in ACI Category:** In response to input from the physician community, CMS has proposed retaining the 90-day reporting period.
8. **More Ways to Earn Bonus Points:**
    a. Eligible clinicians could add bonus points in the scoring methodology for: (1) caring for complex patients; (2) using 2015 Edition CEHRT exclusively; (3) incorporating MIPS performance improvement in scoring quality performance; (4) incorporating the option to use facility-based scoring for facility-based clinicians.
    b. MIPS eligible clinicians, groups, virtual groups and APM entities with 15 or fewer clinicians could receive 5 additional bonus points in their Final Score by submitting data on at least one performance category in the 2018 MIPS performance period.
    c. Small practices but not larger ones could continue to receive 3 extra points for measures in the Quality performance category that don't meet data completeness requirements.

SATINSKY CONSULTING

9. **Weighting MIPS Components:**
    a. Contrary to expectations, for 2018 the Quality component would be weighted at 60% and the Cost component at 0%, allowing practices to continue developing their processes for procuring and interpreting cost data.
    b. Improvement Activities and ACI would remain at their current 15% and 25% respective weights.
    c. CMS' future plans for changing weights remains at raising Cost to 30% for the 2021 MIPS payment year (using 2019 data for reporting) and beyond.
10. **Improvement Scoring for Quality and Cost:** the Proposed Rule adds a mechanism for rewarding improvement in performance for these two categories. Higher improvement would translate to more points.

The deadline for submission of comments to CMS on the Proposed Rule is August 18, 2017. Comments can be submitted electronically through Regulations.gov or by mail. When commenting, refer to file code CMS 5522-P.

For additional information, access the comprehensive information provided by CMS, the North Carolina Medical Society, national specialty societies, other professional organizations and software vendors. Refer to the list of resources in our **Early Summer 2017 Newsletter** if you need specific site links and email contacts.

How Can Satinsky Consulting Help Your Practice?

For assistance with the following, please contact us at 919.383.5998 or **margie@satinskyconsulting.com**.

- Medical Practice Start-up & Expansion
- Assistance in Setting Up Concierge, Direct Pay, & Integrative Medicine Practices
- HIPAA Privacy and Security Rule Compliance & Training
- Information Technology Planning & Implementation Consulting
- Managed Care Rate Negotiations & Contract Review
- Revenue Cycle Management Consulting
- Strategic Planning
- Operational Analysis & Improvement
- Medical Practice Marketing
- Development of Website Content
- Human Resource Management
- Speaking & Teaching on Medical Practice Management

Satinsky Consulting, LLC
201 Cedar Ridge Way
Durham, NC 27705-1981
919.383.5998
Fax 919.309.0109
www.satinskyconsulting.com