Healthcare is transitioning from volume to value-based reimbursement models. Whether prepared or not, MACRA began impacting the delivery of services to Medicare patients and the reporting to Medicare for most providers Jan 1, 2017. Under the law, physicians must choose between two paths: the Merit-based Incentive Payment System (MIPS) or the Advance Alternative Payment Models. The majority of providers in 2017 are expected to select the MIPS track, which scores physicians on quality, advancing care information and clinical practice improvement – resource utilization will become another metric in 2018.

No matter which track is selected, MACRA is here and will likely be a template for private payers’ own versions of value-based reimbursements in the near future. Thus, physicians need to accept its existence and educate themselves on how to avoid penalties and achieve success under the law. Those who have already started to prepare for this shift are likely aware of the updates made Oct 14, 2016, under the MACRA final rule. Those who have not prepared must do so immediately to mitigate reductions in their 2019 reimbursement, which could occur based on 2017 performance in MIPS.

The following offers a short checklist of steps to help ensure you are adequately prepared for this impactful change.
Be Prepared to Perform Well on 2017 Quality Measures

Physicians have become increasingly adept at meeting reporting requirements over the years. However, physicians must realize that future Medicare reimbursement will now be based on pay-for-performance, not simply pay-for-reporting. Clinicians need to understand how to perform well for each quality measure (QM) selected: the better the performance, the higher the point value and the greater the reimbursement.

Tip: Talk to your EHR and RCM vendors—they can help report claims-based QMs.

When considering which QMs to report, consider what efforts your group or organization is already making. Many physicians are now focusing on improving disease outcomes and increasing preventative screenings – both of which relate to numerous QM measures.

CMS has published the 2017 QM draft specifications. However, a timetable has not been established to publish the final QM specifications.

There are individual and specialty-specific measures, and each practice will have the opportunity to choose the measures that are most applicable to them. Once you have chosen your measures, you must determine how to report these measures. In doing so, keep in mind that there are bonuses available for reporting measures through certified electronic health record technology (CEHRT). If you have questions about documenting or reporting through your EHR, contact your representative to assist with setup, documentation and reporting.

All available QMs can be found here https://qpp.cms.gov/measures/quality.
Establish Infrastructure to Advance Care Information

The MIPS category Advancing Care Information (ACI) replaces the EHR Meaningful Use program, which in 2015 penalized more than 250,000 providers over $200 million in Medicare payments for failing to meet the program’s requirements. The ACI category accounts for 25 percent of the total MIPS score for office-based clinicians.

For some base ACI measures, only one successful instance is required to be reported. Physicians that are not hospital-based only need to report each of the four base ACI measures for a minimum of one individual patient per measure in 2017.

Tip: Confirm whether your EHR is compliant with the 2014 OR 2015 edition of “Certified Electronic Health Record Technology.” Your EHR’s level of compliance will determine if you are required to report four or five ACI measures in 2017.
Select Improvement Activities

Easy wins are available in the Improvement Activates category of MIPS for physicians that already plan and document activities like setting aside time for same-day appointments, medication reconciliation and patient communication.

It’s important to understand that individual clinicians and medical groups must perform and report the Improvement Activities for 90 continuous days during 2017.

Tip: Plan ahead and consider which 90 day period in 2017 would be most suitable for reporting the improvement activities your practices has selected.

What are my options? Select ONE of these three options:

a. Review, select, perform and attest to Improvement Activities that fit your practice. Improvement Activities can be found at https://qpp.cms.gov/measures/ia. Instructions on attestation are still pending from CMS.

b. Consider specialty-specific improvement programs. Recognition as a certified patient-centered medical home, a comparable specialty practice or an APM that is designated as a Medical Home Model automatically awards full credit for this category.

c. Report via a Qualified Clinical Data Registry (QCDR). It is unclear if reporting via QCDR as the only method will provide the opportunity for a maximum score. Thus, we recommend not solely depending on QCDR for first year compliance with Improvement Activities. Instead, just keep this reporting method in mind as one of the possible options.

Longer term, physicians should consider signing up with a QCDR. CMS has repeatedly stated their intent to move away from claims-based reporting, making QCDRs the future of QM reporting. QCDRs are an excellent reporting option for both primary and specialty care providers. Utilizing measures groups for reporting can tailor the quality measures used to the practice specialty and improve reporting performance.
Assess Current Capabilities and Establish Goals

Before choosing which measures and activities to report, it’s important to first conduct an audit of current performance, progress and capabilities. When evaluating MIPS readiness, organizations should assess whether all applicable measures are being appropriately reported, clinicians understand the performance standard required by CMS and physicians have access to their current performance.

For non-hospital-based clinicians in 2017, quality accounts for 60 percent of the total MIPS score, whereas advancing care information makes up 25 percent. Improvement activities round out the remaining 15 percent. Although CMS will measure cost and resource utilization in 2017 for benchmarking and improvement purposes, these metrics won’t start impacting reimbursement until 2020. Therefore, estimating your current performance for the various components of MIPS and establishing a plan to address each is vital. Once you can identify gaps between your current activities and performance and what is required by MIPS, you can adjust accordingly to achieve financial bonuses and avoid penalties.

Preparing for MIPS can appear intimidating, but it’s also important to remember that CMS lowered the reporting requirements in 2017 to limit clinicians’ exposure to penalties and delayed complete implementation of MIPS until Jan. 1, 2018. Both the transition year and delay provide physicians with some additional time to prepare while only reporting a fraction of the data that will be required in 2018. However, it is important to take full advantage of this temporary reprieve by ensuring the necessary components are in place to execute the plan you’ve developed for MIPS in 2018.
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