The Evolving Landscape of Healthcare Payment:

Incentive Programs and ACO Model Optimization

Quality Forum
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Objectives

1. Understand the current ACO landscape.

2. Provide an overview of the Physician Quality Reporting System (PQRS) and Value Based Modifier Programs (VM), and the shift from quantity to quality of care for reimbursement.

3. Discuss the value of participation in PQRS and VM Programs.

4. How to have the conversation of the changing landscape with your hospital staff and your Board.

5. Develop an action item for implementation upon returning to your facility.
Medicare: Shift to ACO Landscape

From

- Nine individuals under 65 contributed to each person over the age of 65.
- 19,000,000 enrolled in Medicare in 1967
- 1982 Prospective Payment System implemented to control costs

To

- Five individuals under 65 who contribute to each person over the age of 65.
- 49,435,610 enrolled in Medicare as of 2012
- 2003 Medicare Modernization Act – mandated hospital inpatient quality reporting, Value Based Purchasing
- 2006 Tax Relief and Health Care Act (PQRS initiation)
- Affordable Care Act extended PQRS incentives through 2014 with penalty beginning in 2015
- 2015 Value – Based Modifier
- 2015 January - HHS announced 85 percent of Medicare payments tie to quality or value by 2016 and 90 percent by 2018
Medicare as a Share of the Federal Budget

Figure 1

Medicare as a Share of the Federal Budget, 2014

Total Federal Outlays, 2014 = $3.5 Trillion
Net Federal Medicare Outlays, 2014 = $505 Billion

NOTE: All amounts are for federal fiscal year 2014. ¹Consists of Medicare spending minus income from premiums and other offsetting receipts. ²Includes spending on other mandatory outlays minus income from offsetting receipts.
Figure 2

Medicare Benefit Payments, 2014

Total Medicare Benefit Payments, 2014 = $597 billion

NOTE: *Consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services; also includes the effect of sequestration on spending for Medicare benefits and amounts paid to providers and recovered.

Healthcare Reform Aim

Better care for individuals

Better health for populations

Lower growth in health care expenditures
The Landscape Has Changed
Value Based Purchasing Domain Weighting

- **2013**: Clinical Process of Care 70%, Patient Experience 30%
- **2014**: Clinical Process of Care 45%, Patient Experience 30%
- **2015**: Clinical Process of Care 30%, Patient Experience 30%, Outcomes 20%
- **2016**: Clinical Process of Care 25%, Patient Experience 25%, Outcomes 40%, Efficiency 10%
Value Based Purchasing Reductions to Providers

- FY 2013: -1.00%
- FY 2014: -1.25%
- FY 2015: -1.50%
- FY 2016: -1.75%
- FY 2017: -2.00%
Medicare ACO’s as of April 2014

Where the ACOs Are
23 Pioneer and 343 Shared Savings Program ACOs\(^1\) as of April 2014

1 Accountable care organization.

Source: The Advisory Board
Medicare ACO’s January 2015

Where the ACOs Are
19 Pioneer and 405 Shared Savings Program ACOs¹ as of January 2015

Source: CMS; Advisory Board analysis.

¹ Accountable Care Organization.
Readmission Penalty Reductions

- Up to a 3% reduction!
- Keep adding the number of conditions that qualify
- Net saver for CMS

<table>
<thead>
<tr>
<th>% of Hospitals Penalized</th>
<th>Avg Hospital Penalty</th>
<th># of Hospitals Penalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.*</td>
<td>-</td>
<td>.63%</td>
</tr>
</tbody>
</table>

* 39 hospitals received the maximum penalty
Hospital Acquired Conditions (HAC) penalty

- FY 2015 a 1% penalty kicks in
- 721 Hospitals are affected this first year
- CMS assessed rates of 10 patient injuries at hospitals
  - Blood stream infections
  - Patient falls
  - Bed sores
  - Urinary tract infections
  - Collapsed lungs
  - Cuts that occur during or after surgery
  - Blood clots
- Net saver for CMS!
Bundled Payments

• Set price for a pre-defined episode of care

• Advantages
  • Simplified, single payment
  • Discourages unnecessary care
  • Reduces line-item coding burden
  • Predictable price

• Most common services so far:
  • Surgery (Orthopedic, General)
  • Obstetrics
# CMS Strategic Vision and Indicators of Success

**Source:** CMS

<table>
<thead>
<tr>
<th>Vision Statement</th>
<th>Indicator of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS quality reporting programs are guided by input from patients, caregivers and healthcare professionals</td>
<td>• Patients, caregivers, and healthcare professionals are key contributors and active participants in measure development, reporting, and quality improvement efforts.</td>
</tr>
<tr>
<td>Feedback and data drives rapid cycle quality improvement</td>
<td>• Technology enables healthcare professionals to monitor quality measure performance on an ongoing basis at the point of care.</td>
</tr>
<tr>
<td></td>
<td>• Quality measurement results drive the planning of quality improvement initiatives.</td>
</tr>
<tr>
<td>Public reporting provides meaningful, transparent, and actionable information</td>
<td>• Meaningful, actionable performance data are accessible to and used by a variety of audiences (e.g., patients, caregivers, and healthcare professionals).</td>
</tr>
<tr>
<td></td>
<td>• Patients and caregivers have timely access to performance information tailored to their needs.</td>
</tr>
<tr>
<td>Quality reporting programs rely on an aligned measure portfolio</td>
<td>• An aligned portfolio of health IT-enabled quality measures supports all CMS public reporting, quality improvement, and value-based purchasing programs.</td>
</tr>
<tr>
<td></td>
<td>• A stable and robust infrastructure exists for developing and implementing health IT-enabled quality measures.</td>
</tr>
<tr>
<td>Quality reporting and value-based purchasing program policies are aligned</td>
<td>• Principles, policies and processes for all CMS quality reporting and value-based purchasing programs are coordinated.</td>
</tr>
</tbody>
</table>
Payers both private and federal are looking for ways to leverage their dollars towards the facilities who do well.
Polling Question: PQRS

1. I have a lot of knowledge of PQRS. The providers / facility has enrolled in the Physician Quality Reporting System (PQRS) through membership of an ACO.

2. The providers / facility have enrolled in PQRS. We are doing well on the measures, and are prepared for an audit.

3. I know a limited amount about PQRS. The providers / facility is not enrolled.

4. I have no knowledge about PQRS and want to learn.
Physician Quality Reporting System (PQRS)

CMS’s goal of PQRS is to collect meaningful data (evidenced based quality measures) that can lead to improved patient care.

So... How do you get started?
• Professional services are paid under or based on the Medicare Physician Fee Schedule

Professionals able to participate:
• **Medicare physicians** (medicine, osteopathy, podiatry, optometry, oral surgery, dental, chiropractic)
• **Practitioners** (PA, NP, clinical nurse specialist, CRNA, CNM, social worker, psychologist, dietician, nutrition professionals, qualified audiologists)
• **Therapists** (PT, OT, Speech)

• Beginning in 2015, CAHs using Method II Billing may participate in PQRS by all reporting mechanisms, including claims – based reporting.

• Source: CMS
Some professionals may be eligible to participate per their specialty, but due to billing method may not be able to participate:

- Professionals who do not bill Medicare at an individual National Provider Identifier (NPI) level, where the rendering provider’s individual NPI is entered on CMS-1500 or CMS-1450 type paper or electronic claims billing, associated with specific line-item services.

- Services payable under fee schedules or methodologies other than the MPFS are not included in PQRS.

Source: CMS
Trends in PQRS Participation 2007 – 2013

Source: CMS

Figure 3: Trends in PQRS Participation (2007 to 2013)

- Eligible, but did not Participate
- Eligible Professionals Participating through Pioneer ACOs
- Eligible Professionals Participating through the CPC
- Eligible Professionals in Practices Participating through SSP ACOs
- Eligible Professionals in Practices Participating Under the GPRO
- Individual Participants
- Participation Rate

Note for Figure 3: Results include all reporting mechanisms and options.
2013 EP’s PQRS Participation Per State

Notes for Figure 16: Results include all individual participation PQRS mechanisms (i.e., claims, registry, and EHR) as well as eligible professionals who belong to a practice that participated under the PQRS GPRO, eligible professionals participating as part of a Medicare ACO under the Shared Savings Plan or Pioneer ACO Model, and eligible professionals participating through the CPC initiative. The data used to populate this map can be found in Appendix Table A15.
Who is NOT able to participate in PQRS?

Most services payable under fee schedules or methodologies other than the MPFS are not included in 2015 PQRS. For example:

- services provided under federally qualified health center
- rural health clinics methodologies
- portable X-ray suppliers
- independent laboratories including place-of-service code “81,”
- skilled nursing facilities
- ambulance providers
- and ambulatory surgery center facilities
- suppliers of durable medical equipment (DME) are not eligible to report measures via PQRS since DME is not paid under the MPFS.
Individual EPs are identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN).

A group practice under 2015 PQRS is defined as a single Tax Identification Number (TIN) with 2 or more individual EPs who have reassigned their billing rights to the TIN.

Group practices can register to participate in PQRS via the group practice reporting option (GPRO) to be analyzed at the group (TIN) level. Group practices participating via GPRO are referred to as PQRS group practices.

Source: CMS
#2 Eligible Professional Group Definitions

- The group practices determine their size based on the number of EPs (NPIs) billing under the TIN at the time of registration.

- During registration, group size will be categorized as 2-24 EPs, 25-99 EPs and 100 or more EPs.

- The group practice will need to indicate their group size to CMS by selecting one of these size categories. Reporting requirements and available reporting methods will vary based on the group size.

- Source: CMS
Eligible Professionals and the Shared Savings ACO Program

• Eligible professionals who are participating in a Shared Savings ACO program are given credit for PQRS and may also satisfy the EHR Incentive Programs
Individual EPs may choose to report on individual PQRS quality measures or measures groups the following ways:

- (1) **Medicare Part B claims**
- (2) **Qualified PQRS registry**
- (3) **Direct electronic health record (EHR)** using certified EHR technology (CEHRT)
- (4) CEHRT via **data submission vendor**
- (5) **Qualified clinical data registry (QCDR)**

Group Practices may choose to report on PQRS quality measures using the following mechanisms:

- (1) **Qualified PQRS registry**
- (2) **Web Interface** (for groups of 25+ only)
- (3) **Direct EHR** using CEHRT
- (4) CEHRT via **data submission vendor**
- (5) CAHPS for PQRS via **CMS-certified survey vendor** (for group practices of 2+) to supplement PQRS group practice reporting
• Individual EPs and PQRS group practices should choose at least 9 individual measures across 3 National Quality Strategy (NQS) domains or:

• 1 measures group as an option to report on measures to CMS (with the exception of group practice reporting option (GPRO) Web Interface).

• Individual EPs or PQRS group practices are also required to report one (1) cross-cutting measure (diabetic care, pain management, medication management, tobacco use) if they have at least one (1) Medicare patient with a face-to-face encounter.
2015 National Quality Strategy Measure Domains

Source: CMS

- Patient Safety
- Person and Caregiver-Centered Experience and Outcomes
- Communication and Care Coordination
- Effective Clinical Care
- Community/Population Health
- Efficiency and Cost Reduction
## Top 5 Individual PQRS Measures 2013

Source: CMS

### Table 3: Top Five Individual PQRS Measures Reportable by the Largest Number of Eligible Professionals (2013)

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Name</th>
<th>Eligible Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>321</td>
<td>Participation by a Hospital, Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality</td>
<td>701,240</td>
</tr>
<tr>
<td>131</td>
<td>Pain Assessment and Follow-Up</td>
<td>664,919</td>
</tr>
<tr>
<td>130</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>663,342</td>
</tr>
<tr>
<td>128</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
<td>639,568</td>
</tr>
<tr>
<td>317</td>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
<td>634,348</td>
</tr>
</tbody>
</table>
## PQRS Timeline 2015 – 2017

<table>
<thead>
<tr>
<th>DATE</th>
<th>MILESTONES</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 2015</td>
<td>First day to register through the PV-PQRS Registration System to participate in 2015 PQRS via GPRO</td>
<td>• <a href="#">2015 PQRS GPRO Criteria</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <a href="#">PQRS GPRO webpage</a></td>
</tr>
<tr>
<td>June 30, 2015</td>
<td>Last day to register through the PV-PQRS Registration System to participate in 2015 PQRS via GPRO</td>
<td>• <a href="#">2015 PQRS GPRO Criteria</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <a href="#">PQRS GPRO Web Interface</a></td>
</tr>
<tr>
<td>December 31, 2015</td>
<td>Reporting for the 2015 PQRS program year ends for both group practices and individuals. (Note: 2015 program year data will determine the 2017 payment adjustment)</td>
<td>• <a href="#">Analysis and Payments</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <a href="#">Payment Adjustment Information</a></td>
</tr>
</tbody>
</table>

[www.eidebailly.com](http://www.eidebailly.com)
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</thead>
<tbody>
<tr>
<td>January 1, 2016</td>
<td>Reporting for the 2016 PQRS program year begins for both group practices and individuals (Note: 2016 program year data will determine the 2018 payment adjustment) Payment adjustments begin for both group practices and individuals who did not satisfactorily report quality data to CMS in 2014</td>
<td>• 2016 resources to be posted to PQRS website</td>
</tr>
<tr>
<td>February 26, 2016</td>
<td>Last day that 2015 claims will be processed to be counted for PQRS reporting to determine the 2017 payment adjustment</td>
<td>• 2015 resources to be posted to PQRS website</td>
</tr>
<tr>
<td>February 29, 2016</td>
<td>Last day to submit 2015 CQMs for dual participation in PQRS and the Medicare EHR Incentive Program Last day for QCDRs (QRDA) and EHRs to submit 2015 data</td>
<td>• Clinical Quality Measure webpage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 2015 resources to be posted to PQRS website</td>
</tr>
<tr>
<td>March 31, 2016</td>
<td>Last day for QCDRs (QCDR XML only) and registries to submit 2015 data</td>
<td></td>
</tr>
<tr>
<td>April 30, 2016</td>
<td>QCDRs must post 2015 quality measure data as directed by MPFS final rule</td>
<td></td>
</tr>
<tr>
<td>December 31, 2016</td>
<td>Reporting for the 2016 PQRS program year ends for both group practices and individuals (Note: 2016 program year data will determine the 2018 payment adjustment)</td>
<td>• 2016 resources to be posted to PQRS website</td>
</tr>
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Individual (EPs) and group practices who do not satisfactorily report data on quality measures for covered professional services will be subject to a negative payment adjustment under the (PQRS) beginning in 2015.

- 2013 program participation will affect 2015 payments by a 1.5% negative payment.

- 2015 program participation will affect 2017 payments by a 2% negative payment.

The PQRS negative payment adjustment applies to all of the EP’s or group practice’s Part B covered professional services under the Medicare Physician Fee Schedule (MPFS).
How Does PQRS Fit?

Report quality measures for PQRS

**EHR**
PQRS data are used as part of the Medicare EHR Incentive Program.
- The Medicare EHR Incentive Program provides incentive payments to individual EPs, eligible hospitals, and critical access hospitals (CAHs) who adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology (CEHRT).
- The Medicare EHR Incentive Program asks providers to demonstrate meaningful use of the capabilities of their EHRs to achieve benchmarks that can lead to improved patient care.

**Value Modifier**
PQRS data are used to calculate a physician’s Value Modifier.
- Value Modifier is calculated using quality of care and cost data. All physicians who participate in Fee-For-Service Medicare will be affected by the Value Modifier starting in 2017.
- In order to be eligible for upward, downward, or neutral payment adjustments under the Value Modifier quality-tiering methodology, and to avoid an automatic negative Value Modifier payment adjustment in 2017, EPs in groups and solo practitioners MUST participate in PQRS and satisfy reporting requirements as a group or as an individual in 2015.

**Physician Compare**
Several PQRS measures are housed in Physician Compare, information about individual EPs and group practices who satisfactorily participated in CMS quality programs.
- Individual EPs and group practices can compare their performance on pre-determined measures with the performance of their peers.
- This website:
  1. Enables individual EPs and group practices to track their performance against established metrics
  2. Allows consumers to make informed choices about the health care they receive.
So.. Should You / Facility Still Sign up for PQRS?

• If you are an “Eligible Professional” in 2015 the answer is YES!
  • 2015 PQRS via the GPRO, group practices must have registered by June 30, 2015.
  • Individual EPs do not need to sign up or pre-register in order to participate in PQRS.
  • Make sure you are participating in the correct reporting year.

WHY?

2 Categories:
1. 2015 PQRS reporters
2. Non 2015 PQRS reporters - automatic penalty 2017
Figure 1: Number of Eligible Professionals Who Qualified for an Incentive Payment: PQRS (2007 to 2013) and eRx Incentive Program (2009 to 2013)

- Eligible Professionals who were incentive eligible through participation in the CPC Initiative
- Eligible Professionals who were part of a practice that earned an incentive as part of an SSP ACO
- Eligible Professionals who were part of a practice that earned an incentive as part of a Pioneer ACO
- Eligible Professionals who were part of a practice that earned an incentive under the GPRO
- Eligible Professionals who earned an incentive (individuals)

Note for Figure 1: Results include all participation options (i.e. individual, GPRO, SSP and Pioneer ACOs, and the CPC initiative)
What’s Next in the Alignment of Reporting

- The Physician Quality Reporting System (PQRS) will end in 2018.

- The Affordable Care Act
  - Value- Based Payment Modifier (VBM) will be phased in which will apply to FFS payments starting in 2015, and impacting all physicians by 2017.

- Merit –based Incentive Payment System (MIPS) begins.

- The Goal: Improve the care of Medicare beneficiaries, provide a common base of reporting to decrease burden, and place the emphasis on reporting quality performance.
Value – Based Modifier Payment Program (VM)

• **Evaluates:**
  - The performance of solo practitioners and groups of practitioners, as identified by their Taxpayer Identification Number (TIN) on the care that they provide to their Fee-for-Service Medicare beneficiaries during a performance period.

• **Focus:**
  - Quality of care
  - Cost of care

• **Reporting Mechanism:**
  - The Centers for Medicare & Medicaid Services (CMS) disseminates this information to TINs in confidential Quality and Resource Use Reports (QRURs).

• **Budget Neutral – zero sum gain in reward / penalty**
Relationship between Quality of Care, Cost Composites and Value-Based Modifier (VM) Source: CMS

Clinical care

Patient experience

Population/Community Health

Patient safety

Care coordination

Efficiency

Total per capita costs

Per capita costs for beneficiaries with specific conditions

Quality of Care Composite

Value Modifier Score

Cost Composite
Value – Based Modifier (VBM) – The Phase In:

Value Modifier in 2015 based on performance in 2013 for groups of 100 or more eligible professionals (EPs).

In 2016, the Value Modifier applies to groups of physicians with 10 or more EPs based on 2014 performance.

The Value Modifier applies to all physicians and groups of physicians starting in 2017.

For 2015 and 2016, the Value Modifier does not apply to groups of physicians in which any of the group’s physicians participate in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care initiative during 2013 and 2014, respectively.

For 2017, the Value Modifier applies to participants in the Medicare Shared Savings Program, Pioneer ACO Model, and Comprehensive Primary Care Initiative.

For 2018, the Value Modifier will also apply to Medicare PFS payments made to non-physician EPs.
Who is your Beneficiary

Two step process to associate a beneficiary to a TIN in the year the performance is assessed.

• If a beneficiary did not utilize services in the year the performance is assessed, no TIN is assigned.
Who is your Beneficiary

Step 1: If the TINs primary care physicians (PCPs) have provided the larger share of the charges for primary care in the performance year, the beneficiary is attributed to the TIN.

- If there are two PCPs have provided services equally to the beneficiary, the one who provided services most recently will be attributed.

Step 2: Those beneficiaries that do not meet Step 1, but receive care from a primary care physician regardless of the specialty are assigned to the TIN whose physicians, NPs, PAs etc… have accounted for the larger share of Medicare charges.
Value – Based Modifier (VM) - Who is your beneficiary

Is the beneficiary excluded from attribution?

- No.
  - Yes. Beneficiary not attributed to any TIN.

Did the beneficiary receive any primary care services from a physician?

- Yes.
  - No. Beneficiary not attributed to any TIN.

- No.
  - Yes. Beneficiary attributed to TIN with Step 1 Professionals accounting for more allowed charges for primary care services than any other TIN.

Did the beneficiary receive any primary care services from a Step 1 Professional?

- No.
  - Yes. Beneficiary attributed to TIN with Step 2 Professionals accounting for more allowed charges for primary care services than any other TIN.

- No. Beneficiary not attributed to any TIN.
# Value – Based Modifier Timeline

**Source:** Hart Health Strategies

<table>
<thead>
<tr>
<th>Year</th>
<th>Action</th>
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<tbody>
<tr>
<td>2012</td>
<td>CMS provided confidential feedback reports to all successful PQRS participants to demonstrate the type of information that will be used to calculate the VBM</td>
</tr>
<tr>
<td>2013</td>
<td>Initial performance period began for large group practices only (≥100 eligible professionals)</td>
</tr>
<tr>
<td>2014</td>
<td>Performance period begins for group practices with ≥10 eligible professionals.</td>
</tr>
</tbody>
</table>
| 2015 | • Initial application of the payment modifier for large group practices only (≥100 eligible professionals) based on 2013 performance  
   • Performance period begins for ALL physicians |
| 2016 | Application of the payment modifier to group practices with ≥10 eligible professionals based on 2014 performance |
| 2017 | Application of the payment modifier to ALL physicians based on 2015 performance |
How CMS Calculates the Value-Based Modifier for CY 2015

Groups of Physicians with 100 or more Eligible Professionals

PQRS Participation (Groups that self-nominate/register for PQRS as a group and report at least one measure, or elect PQRS Administrative Claims)

Elect Quality-Tiering Calculation

Upward, downward, or no adjustment based on quality-tiering

Non-PQRS Participation (Groups that do not self-nominate/register for PQRS as a group and do not report at least one measure)

No Election

0.0% (no adjustment)

-1.0% (downward adjustment)
Value-Based Modifier Application 2017

Groups with 2-9 EPs and solo practitioners

2-9 EPs: 2015 PQRS
GPRO Reporters (registry, EHR)

Solo practitioners: 2015 PQRS report (claims, registry, EHR, or QCDR)

Positive (up to +2.0x), or neutral adjustment based on quality tiering
*no downward adjustment

Non-PQRS Reporters in 2015

-2.0%* VBM adjustment
*in addition to -2.0% PQRS penalty

Source: Hart Health Strategies Inc.
Value-Based Modifier Application 2017

Groups with ≥ 10 EPs

PQRS GPRO Reporters in 2015 (registry, EHR or Web Interface)

Positive (up to +4.0x), neutral, or negative (up to -4.0%) adjustment based on quality tiering

Non-PQRS Reporters in 2015

-4.0%* VBM adjustment

*in addition to -2.0% PQRS penalty

Source: Hart Health Strategies Inc.
Proposed Policies for the 2018 Value-Based Modifier

Source: CMS

**PQRS Reporters – 3 types – Category 1**
1a. Group reporters: Report as a group via a PQRS GPRO and meet the criteria to avoid the 2018 PQRS payment adjustment
   **OR**
1b. Individual reporters in the group: at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment
2. Solo practitioners: Report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment

**Mandatory Quality-Tiering Calculation**
- Physicians, PAs, NPs, CNSs, & CRNAs in groups with 2-9 EPs and physician solo practitioners
- Physicians, PAs, NPs, CNSs, & CRNAs in groups with 10+ EPs
- Groups & solo practitioners consisting of non-physician EPs

**Upward, no, or downward VM adjustment based on quality-tiering**
-2.0% to +2.0x

**Non-PQRS Reporters – Category 2**
1. Groups: Do not avoid the 2018 PQRS payment adjustment as a group OR do not meet the 50% threshold option as individuals
2. Solo practitioners: Do not avoid the 2018 PQRS payment adjustment as individuals

-2.0% (for physicians, PAs, NPs, CNSs, & CRNAs in groups with 2-9 EPs, physician solo practitioners, & groups and solo practitioners consisting of non-physician EPs)
-4.0% (for physicians, PAs, NPs, CNSs, & CRNAs in groups with 10+ EPs)
(Automatic VM downward adjustment)

**Note:** The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

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MACRA amends section 1848(a)(8)(A) of the Social Security Act affecting the quality reporting programs

- PQRS ends in 2018, certain aspects of the program may be incorporated under the new incentive program
- EHR Meaningful Use Incentive payments will be made under MIPS as below
- Value-based payment modifier adjustments will be combined under MIPS as below
- Payment Modifier will not be applied for items and services furnished on or after January 1, 2019

MACRA created the Merit-Based Incentive Payment System (MIPS) and incentive payments for participation in eligible alternative payment models beginning in 2019

MIPS replaces the sustainable growth rate

Components of the MIPS include:

- MIPS Adjustment Factor/Scoring
- Composite Performance Score
- Performance Threshold
PQRS and VM Participation Value To You
Polling Question:

What would a penalty percent (1-6%) do to your bottom line?

1. No impact to our bottom line

2. It would be tough but we could recover in time

3. It would be devastating to our facility
"DATA IS THE NEW OIL."

From the beginning of recorded time until 2003, we created 5 exabytes of data. In 2003 the same amount was created every two days. By 2015 it will be 17 billion DVDs, 100,000 cars, the weight of a million Hummers. By 2016 almost all languages will be in the top 10. English is the dominant language of the internet. By 2011 it will be Chinese. 80% of all internet access is now via smartphones. 10% are on tablets. In 2016, 100,000 text messages are sent every second. 247 billion emails are sent every day. 50% are spam. 5 million records are stolen every day. These specialized algorithms now make all-second decisions to buy or sell commodities. High-speed traders are making money by the millisecond. 5 milliseconds. How they save 5 milliseconds.

Disruptive - Health Care Data
Disruptive – Technologies
What is your reputation value as a quality provider / facility?

How do you market the upcoming Physician Compare reports?
Conversations of the Changing Landscape

- With the Staff in your Organization
- With the Board
## Examples of Action Steps

### Vision Statement

<table>
<thead>
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<th>Example of Action Steps</th>
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<td>CMS quality reporting programs are guided by input from patients, caregivers and healthcare professionals</td>
</tr>
<tr>
<td>Engage specialty societies and other stakeholders in the development of quality measures that apply to a wider range of specialists and provider types.</td>
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<tr>
<td>Explore new methods for gathering first-hand input from patients and caregivers, such as online response forms or mobile apps.</td>
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<td>Feedback and data drives rapid cycle quality improvement</td>
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<tr>
<td>Engage in collaborative efforts to align performance results with clinical decision support tools.</td>
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<td>Expand QRURs to provide more detailed data to drive improved performance.</td>
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<td>Work with those advancing health IT and HIE to support efforts to optimize technology for quality improvement.</td>
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<td>Collaborate with local and regional quality improvement organizations to use CMS quality data to inform the design of quality improvement programs.</td>
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<tr>
<td>Explore tighter linkages between CMS-enabled learning networks and quality improvement efforts and CMS quality reporting programs.</td>
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<tr>
<td>Public reporting provides meaningful, transparent, and actionable information</td>
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<tr>
<td>Include patients, caregivers, and healthcare professionals as active participants in the design of future public reporting efforts.</td>
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<tr>
<td>Encourage greater participation by healthcare professionals in CMS quality reporting programs, and increased access to and utilization of CMS-provided data.</td>
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<tr>
<td>Pursue collaborative relationships with data aggregators to expand the reach of CMS quality data and the ability of users to access it.</td>
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<tr>
<td>Quality reporting programs rely on an aligned measure portfolio</td>
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<td>Collaborate with measure and standards developers to ensure the data for measures are standardized to support quality improvement programs, public reporting, and payment efforts.</td>
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<tr>
<td>Develop and follow an enterprise-wide measurement strategy focused on patient-centered outcome and longitudinal measures.</td>
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<tr>
<td>Quality reporting and value-based purchasing program policies are aligned</td>
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<tr>
<td>Align policies and processes around payment, registration, data submission, and appeals so they are consistent across all CMS programs.</td>
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</tbody>
</table>
Develop an action item for implementation

• What is your “elevator speech”?
  • Introduce / Reinforce to the Staff in your Organization
  • Market to the Public
  • To the Board

• Identify action step(s) at your table.
How it comes together

Source: CMS
Questions?

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Thank You!

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