Medicare 2018

Rural Health Clinic Quality Meeting

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Updates

1. EHR/PQRS/QPP
2. New Medicare Card
3. Patients over Paperwork (PoP)
On November 4, 2016, CMS published the Medicare Program; MIPS and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models final rule with comment period (CMS-5517-FC) which establishes MIPS, a new program for certain Medicare-enrolled practitioners.

MIPS consolidates components of three existing programs, the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for EPs, and focuses on quality—both a set of evidence-based, specialty-specific standards as well as practice based improvement activities; cost; and use of certified EHR technology (CEHRT) to support interoperability and advanced quality objectives in a single, cohesive program that avoids redundancies.
CMS published the “Participating in the EHR Incentive Programs vs. MIPS in 2017” fact sheet, which provides a comprehensive overview of the EHR Incentive Programs and the Merit-based Incentive Payment System (MIPS), compares reporting and participation requirements for both programs, and provides resources for more information.

Visit the Quality Payment Program Resource Library to review the fact sheet and other Quality Payment Program materials.
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides for two participation tracks:

**MIPS**

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.

**OR**

**Advanced APMs**

Advanced Alternative Payment Models (Advanced APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.
MIPS Year 2 (2018)

Who is Included?

*No change* in the types of clinicians eligible to participate in 2018

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
Who is Included?

**Change to the Low-Volume Threshold for 2018.** Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges **AND** providing care for more than 200 Medicare patients a year.

Transition Year 1 (2017) Final

- BILLING >$30,000
- >100

Year 2 (2018) Final

- BILLING >$90,000
- >200

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.
Cost

Basics:

- **Change:** 10% Counted toward Final Score in 2018

- Medicare Spending per Beneficiary (MSPB) and total per capita cost measures are included in calculating Cost performance category score for the 2018 MIPS performance period.

- These measures were used in the Value Modifier and in the MIPS transition year.

- **Change:** Cost performance category weight is **finalized at 10% for 2018.**

- 10 episode-based measures adopted for the 2017 MIPS performance period will not be used.

- We are developing new episode-based measures with significant clinician input and are providing feedback on these measures this fall through field testing.

- This will allow clinicians to see their cost measure scores before the measures are potentially included in the MIPS program.

- We will propose new cost measures in future rulemaking.
MIPS Year 2 (2018)

Improvement Activities

**Basics:**
- 15% of Final Score in 2018
- 112 activities available in the inventory
  - Medium and High Weights remain the same from Year 1
  - Medium = 10 points
  - High = 20 points
- A simple “yes” is all that is required to attest to completing an Improvement Activity

**Number of Activities:**
- No change in the number of activities that MIPS eligible clinicians must report to achieve a total of 40 points.

**Burden Reduction Aim:** MIPS eligible clinicians in small practices and practices in a rural areas will continue to report on no more than 2 activities to achieve the highest score.

**Patient-centered Medical Home:**
- We finalized the term “recognized” is equivalent to the term “certified” as a patient centered medical home or comparable specialty practice.
- 50% of practice sites* within a TIN or TINs that are part of a virtual group need to be recognized as patient-centered medical homes for the TIN to receive the full credit for Improvement Activities in 2018.

*We have defined practice sites as the practice address that is available within the Provider Enrollment, Chain, and Ownership System (PECOS).*
Advancing Care Information

Basics:
- 25% of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition

CEHRT Requirements:
- Burden Reduction Aim: MIPS eligible clinicians may use either the 2014 or 2015 CEHRT or a combination in 2018.
- A 10% bonus is available for using only 2015 Edition CEHRT.

Measures and Objectives:
- CMS finalizes exclusions for the E-Prescribing and Health Information Exchange Measures.

Scoring:
- No change to the base score requirements for the 2018 performance period/2020 payment year.
- For the performance score, MIPS eligible clinicians and groups will earn 10% for reporting to any one of the Public Health and Clinical Data Registry Reporting measures as part of the performance score.
- For the bonus score a 5% bonus score is available for reporting to an additional registry not reported under the performance score.
- Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus for completion of at least 1 of the specified Improvement Activities using CEHRT.
- Total bonus score available is 25%
Advancing Care Information

Basics:
- 25% of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition

Exceptions:
- Based on authority granted by the 21st Century Cures Act and MACRA, CMS will reweight the Advancing Care Information performance category to 0 and reallocate the performance category weight of 25% to the Quality performance category for the following reasons:

  Automatic reweighting:
  - Hospital-based MIPS eligible clinicians;
  - Non-Patient Facing clinicians;
  - Ambulatory Surgical Center (ASC)— based MIPS eligible clinicians, finalized retroactive to the transition year;
  - Nurse practitioners, physician assistants, clinical nurse specialist, certified registered nurse anesthetists

  Reweighting through an approved application:
  - New hardship exception for clinicians in small practices (15 or fewer clinicians);
  - New decertification exception for eligible clinicians whose EHR was decertified, retroactively effective to performance periods in 2017.
  - Significant hardship exceptions—CMS will not apply a 5-year limit to these exceptions;
  - New deadline of December 31 of the performance year for the submission of hardship exception applications for 2017 and future years.
  - Revised definition of hospital-based MIPS eligible clinician to include covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital (POS 19).
MIPS Year 2 (2018)

Performance Threshold & Payment Adjustment

**Change:** Increase in Performance Threshold and Payment Adjustment

### 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.
Complex Patient Bonus

**New: Complex Patient Bonus**

- Up to **5 bonus points** available for treating complex patients based on medical complexity.
  - As measured by Hierarchical Condition Category (HCC) risk score and a score based on the percentage of dual eligible beneficiaries.

- MIPS eligible clinicians or groups **must submit data on at least 1 performance category** in an applicable performance period to earn the bonus.

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**New: Small Practice Bonus**

- **5 bonus points** added to final score of any MIPS eligible clinician or group who is in a small practice (15 or fewer clinicians), so long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period.

- **Burden Reduction Aim:**
  - We recognize the challenges of small practices and will provide a 5 point bonus to help them successfully meet MIPS requirements.
CMS knows that areas affected by the recent hurricanes, specifically Hurricanes Harvey, Irma, and Maria, have experienced devastating disruptions in infrastructure and clinicians face challenges in submitting data under the Quality Payment Program.

We have issued an **Interim Final Rule** with an automatic extreme and uncontrollable circumstances policy where clinicians are exempt from the Quality, Improvement Activities, and Advancing Care Information performance categories **without** submitting a hardship exception application.

**What does the Interim Final Rule mean for me in the Transition Year (2017)?**

- We will automatically reweight the Quality, Improvement Activities, and Advancing Care Information performance categories.

- This will result in the clinician receiving a MIPS Final Score equal to the performance threshold, unless the MIPS eligible clinician submits data.

- Clinicians who do submit data (as an individual or group) will be scored on their submitted data.

- This policy does not apply to APMs.
The MACRA statute created two pathways to allow eligible clinicians to become QPs.

**Medicare Option**

- Available for all performance years.
- Eligible clinicians achieve QP status exclusively based on participation in Advanced APMs within Medicare fee-for-service.

**All-Payer Combination Option**

- Available starting in Performance Year 2019.
- Eligible clinicians achieve QP status based on a combination of participation in Advanced APMs within Medicare fee-for-service, **AND** Other Payer Advanced APMs offered by other payers.
CMS has free resources and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

**PRIMARY CARE & SPECIALIST PHYSICIANS**
Transforming Clinical Practice Initiative
- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs) are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPliscMail@us.ibm.com for extra assistance.

**SMALL & SOLO PRACTICES**
Small, Underserved, and Rural Support (SURS)
- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
- For more information or for assistance getting connected, contact OPSSURS@impaqpoint.com

**LARGE PRACTICES**
Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)
- Supports clinicians in large practices (more than 15 clinicians) in meeting Merit-Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

**TECHNICAL SUPPORT**
All Eligible Clinicians Are Supported By:

- **Quality Payment Program Website**: [qpp.cms.gov](http://qpp.cms.gov)
  Serves as a starting point for information on the Quality Payment Program.

- **Quality Payment Program Service Center**
  Assists with all Quality Payment Program questions.
  1-866-268-6292 TTY: 1-877-715-6222 [qpp@cms.hhs.gov](mailto:qpp@cms.hhs.gov)

- **Center for Medicare & Medicaid Innovation (CMMI) Learning Systems**
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.
  More information about the Learning Systems is available through your model’s support inbox.

New Medicare Card

MEDICARE HEALTH INSURANCE

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a
HOSPITAL (PART A) 03-01-2016
MEDICAL (PART B) 03-01-2016
The Health Insurance Claim Number (HICN) is a Medicare beneficiary’s identification number, used for processing claims and determining eligibility for services across multiple entities (e.g., Social Security Administration (SSA), Railroad Retirement Board (RRB), States, Medicare providers & health plans).

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires removal of the Social Security Number (SSN)-based HICN from Medicare cards to address current risk of beneficiary medical identity theft.

MACRA requires that CMS mail out new Medicare cards with a new Medicare Number by April 2019.

The new Medicare numbers won’t change Medicare benefits. People with Medicare can start using their new Medicare cards right away.
New Medicare Number

- New Non-Intelligent Unique Identifier
- 11 bytes
- Key positions 2, 5, 8 & 9 will always be alphabetic
New Card! New Number!

1-800-MEDICARE (1-800-633-4225)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO
HOSPITAL (PART A) 07-01-2016
MEDICAL (PART B) 07-01-2016

SIGN HERE
Jane Doe

MEDICARE HEALTH INSURANCE

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a
HOSPITAL (PART A) 03-01-2016
MEDICAL (PART B) 03-01-2016

Coverage starts/Cobertura empieza 03-01-2016
Sending New Medicare Cards

- Medicare starts mailing new cards in April 2018
  - Newly-eligible beneficiaries will get a card with a unique number, regardless of where they live
  - Existing beneficiaries will get a new card over a period of approximately 12 months
  - Distribution of cards will be randomized by geographic location

- Starting in April, people with Medicare will be able to go to Medicare.gov/newcard to sign up for emails about the card mailing and to check the card mailing status in their state

- People with Medicare should use the new card once they get it, but either the SSN-based or the new random alphanumeric-based numbers can be used through December 2019

- Beginning January 1, 2020 only the new card will be usable
New Medicare Cards - Providers

- Look at your practice management systems and business processes and determine what changes you need to make to use the new Medicare Beneficiary Identifier (MBI). You’ll need to make those changes and test them by April 2018, before we mail out new Medicare cards.

- If you use vendors to bill Medicare, you should contact them to find out about their MBI practice management system changes.

- Even though we’ll stop using Social Security Numbers to identify Medicare beneficiaries, what won’t change is how your Social Security Number’s used for the IRS and tax reasons, like on your W-9.
New Medicare Card - Providers

- Automatically accepting the new MBI from the remittance advice (835) transaction.
- Identifying patients who qualify for Medicare under the Railroad Retirement Board (RRB).
- If you don’t already have access to your MAC’s provider portal, sign up so you can use the provider MBI look-up tool starting in June 2018. Your office/facility staff might want to coordinate with your billing/administrative staff, who may already have portal access.
- You'll also want to attend our calls to get more information about this project; we’ll let you know about upcoming calls through MLN Connects.

https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Providers.html
This is your official Medicare card. It's for your use only. For your protection, Medicare cards have a unique number that's different from a Social Security number. Show your card when you get health services. Turn over to read more.

10 things to know about your new Medicare card

Medicare is mailing new Medicare cards starting in April 2019. Here are 10 things to know about your new Medicare card:

1. Mailing takes time: Your card may arrive at a different time than your friend's or neighbor's.
2. Destroy your old Medicare card. Once you get your new Medicare card, destroy your old Medicare card and start using your new card right away.
3. Guard your card: Only give your new Medicare Number to doctors, pharmacists, other health care providers, your insurers, or people you trust to work with Medicare on your behalf.
4. Your Medicare Number is unique: Your card has a new number instead of your Social Security Number. This new number is unique to you.
5. Your new card is paper: Paper cards are easier for many providers to use and copy, and they save taxpayers a lot of money. Plus, you can print your own replacement card if you need one.
6. Keep your new card with you: Carry your new card and show it to your health care providers when you need care.
7. Your doctor knows it's coming: Doctors, other health care facilities and providers will ask for your new Medicare card when you need care.
8. You can find your number: If you forget your new card, you, your doctor or other health care provider may be able to look up your Medicare Number online.
9. Keep your Medicare Advantage Card: If you're in a Medicare Advantage Plan (like an HMO or PPO), your Medicare Advantage Plan ID card is your main card for Medicare -- you should still keep and use it whenever you need care. However, you may also be asked to show your new Medicare card, so you should carry this card too.
10. Help is available: If you don't get your new Medicare card by April 2019, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
At CMS, our top priority is putting patients first. CMS Administrator Seema Verma launched the “Patients over Paperwork” initiative, which is in accord with President Trump’s Executive Order that directs federal agencies to “cut the red tape” to reduce burdensome regulations. Through “Patients over Paperwork,” CMS established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience. In carrying out this internal process, CMS is moving the needle and removing regulatory obstacles that get in the way of providers spending time with patients.
CMS aims

- Increase the number of satisfied customers – clinicians, institutional providers, health plans, etc. engaged through direct and indirect outreach;
- Decrease the hours and dollars clinicians and providers spend on CMS-mandated compliance; and
- Increase the proportion of tasks that CMS customers can do in a completely digital way.
How does “Patients over Paperwork” work?

- **Steering Committee:** Patients over Paperwork is well underway. We have established an executive level Burden Reduction Steering Committee, which will take the lead on coordinating burden reduction across all of CMS. This Steering Committee oversees and prioritizes these reform efforts and ensures we have the right collaboration across the Agency to drive results.

- **Customer Centered Workgroups:** We established customer-centered workgroups focusing first on clinicians, beneficiaries, and institutional providers. The job of these workgroups is to learn from and understand the customer experience, internalize it, and remember these perspectives as we do this work. Over time, we will establish similar workgroups for health plans, states and suppliers.

- **Journey Mapping:** We will use tools to capture customer perspectives, like human-centered design and journey mapping the customer experience. Also, we will establish mechanisms to share across CMS what we learn from our customers so we all benefit from that input. We will develop multiple stakeholder journey maps over the coming months.
What we are hearing:
CMS has listened to you and we are starting to address burden areas we have heard the most about:

- Payment policy,
- Quality measures,
- Documentation requirements,
- Conditions of participation, and
- Health IT.
Patients Over Paperwork Actions

- **Listening Sessions**: CMS has already begun and will continue to hold listening sessions, meetings, customer centered workgroups and other gatherings across the country. We understand how valuable it is to hear directly from healthcare providers and beneficiaries. Our commitment is to keeping patients first and to do that we must hear firsthand from them and the people who care for them every day.

- **Reducing burden through rule making**: As part of our commitment to hearing from our stakeholders about the burden of regulations, CMS solicited comments on specific ideas to reduce those burdens through several Requests for Information in 2017. We received thousands of comments from the public and are actively reviewing them to determine which ones we can address through rule-making in 2018. We will continue to solicit ideas for ways to reduce regulatory burden on an ongoing basis, and look forward to working with our stakeholders to better understand their experiences with CMS regulations.

- **Sub-regulatory Changes**: While much of the burden providers experience is due to CMS regulations, we know that there are many policy changes that CMS could make to address provider pain points that do not require rule-making. We call these sub-regulatory changes. In our listening sessions and from comments received in response to the Requests for Information, we have heard a number of ideas on ways in which we could ease burden on providers that we can implement on a faster timeline through updated guidance, FAQs or other mechanisms. We are actively working to identify and implement these improvements.
Patients Over Paperwork

We’re putting patients first by reviewing and streamlining our regulations so we can:

- Reduce unnecessary burden
- Increase efficiencies
- Improve the beneficiary experience

Find information for you

- Clinicians
- Hospitals
- Nursing facilities
- DME & pharmacy suppliers
- Health plans
- States

Learn how we’re putting patients over paperwork

- Implementing MACRA to lessen your burden & costs
- Cutting documentation requirements
- Making the medical review process clearer
- Making it easier for people to get the treatment they need
- Making Meaningful Measures
- Lowering drug costs

Featured video

**It is recommended to view the video below with Flash disabled in Chrome, Firefox, or Internet Explorer 11 browsers, due to known usability issues with other browsers.

Patients Over Paperwork - Burden Reduction
Questions?