THE PROVIDER ALLIANCE

A newsletter brought to you by CHPA - Community Health Provider Alliance

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2017 ACO Quality Reporting and Quality Payment Program

The Shared Savings Program and MIPS Interactions guide available in the Quality Payment Program Resource Library describes Merit-Based Incentive Payment System (MIPS) scoring and eligibility for eligible clinicians (ECs) participating in an ACO.
In summary, when an ACO successfully reports quality data:

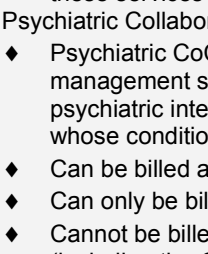
- ECs participating in your ACO, as of August 31, 2017, will receive a MIPS quality performance score using the CMS Web Interface data reported by the ACO.
- ECs participating in your ACO, as of August 31, 2017, will receive full credit for Improvement Activities. ECs who join after August 31, 2017, will receive 50 percent credit for Improvement Activities.
- ECs will need to report Advancing Care Information to MIPS. MIPS requires that ECs participating in an ACO report Advancing Care Information (ACI) as a taxpayer identification number (TIN).
- ECs participating in your ACO, as of August 31, 2017, will be scored under the MIPS Alternative Payment Model (APM) Scoring Standard.

The low-volume threshold for MIPS eligibility will be determined at the ACO-level. This means that clinicians and practices below the low volume threshold that are part of an ACO are subject to MIPS under the APM scoring standard, if the ACO, as a whole, is above the low-volume threshold. In summary, when an ACO does not successfully report quality data:

- ECs will receive a quality performance score of zero (unless they have successfully reported to MIPS outside of the ACO as a group or individual).
- ECs will continue to get full credit for Improvement Activities.
- ECs will be assessed on Advancing Care Information at their group or solo practitioner level of reporting.

The timing of when an ACO ends its agreement with the Shared Savings Program can affect how ECs in the ACO will be scored under MIPS. If an ACO ends their agreement before March 31, 2017, then MIPS ECs in the ACO must report to MIPS as a group or solo practitioner and will be subject to regular MIPS scoring rules. However, if an ACO ends their agreement on or after March 31, 2018, then the ACO must continue to report on behalf of their participating ECs. The rules regarding whether an ACO successfully or unsuccessfully reports described above will apply.

Recruitment strategies for Medicare annual wellness visits - link to article



To increase the number of patients who receive Medicare annual wellness visits, physicians and staff both have a role to play. Nursing staff can review the daily schedule to identify patients who are eligible and remind physicians to recommend the service or recommend it themselves, using this approach:

- When talking with patients, start by describing the visit, then try to identify what aspect seems to most interest the patient.
- Emphasize that "Your doctor wants you to get this done. It really helps your doctor help you."
- Explain that the visit allows the patient and provider to talk longer than during a typical office visit.
- Give the patient a health risk appraisal to bring back; this gives the patient a sense of what to expect.
- Brainstorm potential solutions to barriers such as transportation, time, and care of other family members.
- Be knowledgeable, caring, and passionate while not overwhelming the patient.

MedPAC Discusses Medicare ACO Program and Other Payment Issues

Last week the Medicare Payment Advisory Commission (MedPAC) gave an update on the Medicare ACO Program during its meeting. The presentation reviewed the program and how it has evolved and grown in recent years and gave highlights of performance results to date. The discussion of the 2016 performance centered on net ACO performance relative to CMS benchmarks, but commissioners noted increasing research that evaluates ACO performance differently using other comparisons. During the discussion, many commissioners noted the performance of two-sided ACOs and encouraged continued emphasis on two-sided models. Several commissioners expressed support for ACOs and pointed out the need to refine key program methodologies such as benchmarking. MedPAC is not planning to make formal recommendations to Congress this year on the ACO program, but it will release an evaluation of the program later this year in a MedPAC report. MedPAC held several other sessions, listed along with presentation materials here, including sessions on the adequacy of primary care payments and the Merit-Based Incentive Payment System (MIPS). MedPAC has repeatedly noted inadequacy with primary care payment, including for evaluation and management services, and discussed ways to increase those payments. The commission was very critical of MIPS and is likely to recommend to Congress that MIPS be repealed and replaced with a different program. It is uncertain Congress would act in response to this recommendation and no short-term changes are expected.

Brief Medicare Policy Updates

CY 2018 Physician Fee Schedule Final rule (Effective 01/01/2018)

- Creates new care coordination billing codes for RHCs/FQHCs (General Care Management-G0511 and Psychiatric collaborative care model-G0512)
- Adds seven new Telehealth codes:
  - ⇒ HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility);
  - ⇒ CPT code 90785 (Interactive Complexity);
  - ⇒ CPT codes 96160 and 96161 (Health Risk Assessment);
  - ⇒ HCPCS code G0506 (Care Planning for Chronic Care Management);
  - ⇒ and CPT codes 90839 and 90840 (Psychotherapy for Crisis)

General Care Management Code (G0511)

- Includes general care management and behavioral health integration services
- Can be billed alone or in addition to other services during the RHC or FQHC visit
- Can be billed once per month per beneficiary
- Cannot be billed if other care management services (such as TCM or home health care supervision) are billed for the same time period
- Cannot count time spent by administrative or clerical staff towards the time required to bill these services

Psychiatric Collaborative Care Model (G0512)

- Psychiatric CoCM defined: Care model integrating primary health care services with care management support for patients receiving behavioral health treatment, including regular psychiatric inter- specialty consultation with the primary care team, particularly for patients whose conditions are not improving
- Can be billed alone or in addition to services furnished during the RHC or FQHC visit
- Can only be billed once per month per beneficiary
- Cannot be billed if other care management services are billed for the same time period (including the General Care Management code)

New Medicare Card: Web Updates

To help you prepare for the transition to the Medicare Beneficiary Identifier (MBI) on Medicare cards beginning April 1, 2018, review the new information about remittance advices. Beginning in October 2018, through the transition period, when providers submit a claim using a patient's valid and active Health Insurance Claim Number (HICN), CMS will return both the HICN and the MBI on every remittance advice. Here are examples of different remittance advices:

- Medicare Remit Easy Print (Medicare Part B providers and suppliers)
- PC Print for Institutions

Standard Paper Remits: FISS (Medicare Part A/Institutions), MCS (Medicare Part B/Professionals), VMS (Durable Medicare Equipment)

Find more new information on the New Medicare Card provider webpage.

New Medicare Card: When Will My Medicare Patients Receive Their Cards?

Starting April 2018, CMS will begin mailing new Medicare cards to all people with Medicare on a flow basis, based on geographic location and other factors. Learn more about the Mailing Strategy. Also starting April 2018, your patients will be able to check the status of card mailings in their area on Medicare.gov.
For More Information: Mailing Strategy
Questions from Patients? Guidelines
New Medicare Card overview and provider webpages

Press Ganey ACO CAHPS Update

Press Ganey began the phone portion of survey administration on January 4, 2018 for all ACO CAHPS clients, in accordance with the timeline distributed by CMS. ACO CAHPS data collection ends February 1, 2018. Press Ganey will submit all the ACO CAHPS results received by February 1, 2018 to CMS between February 6, 2018 - February 8, 2018, as required by the CMS data submission deadline. Press Ganey ACO CAHPS clients can anticipate receiving their unofficial survey results by April 2018. For more information please see their most recent update here.

Community Health Provider Alliance (CHPA) is an accountable care organization formed around a statewide integrated system of federally-qualified Community Health Centers (CHCs). CHPA was formed to improve care transitions and implement best practices in patient-centered medical home care coordination, to develop alternative payment methodologies and payment reform to decrease overall healthcare costs, and increase patient satisfaction.

If you would like to be added to the newsletter e-mail distribution list, or if you have comments about this newsletter, please contact Jake Rosse, CCHN executive assistant, at jake@cchn.org or (303) 867-9546.

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