Preparing Your Practice for the Changes in Medicare and All of Healthcare – Will You Be Prepared? (2 Hours)

Saturday, May 20, 2017
4:00 – 6:00 PM

NYSOA 122nd Annual Meeting – Continuing Education Program
Otesaga Resort Hotel | Cooperstown, NY

Course Instructor:
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Course Outline:
1. Introduction and Goals
2. Challenges and Opportunities
   a. Government and Payers will continue to add complexity
   b. Patients will increasingly act as consumers
3. Healthcare Trends
   a. The shift away from “Fee-for-Service” to pay for “Fee-for-Value”
4. Alphabet Soup
   a. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
      i. Repeals the Sustainable Growth Rate formula
      ii. Changes the way that Medicare rewards providers for value over volume
      iii. Streamlines multiple quality reporting programs under the Quality Payment Program (QPP) into MIPS and APM
      iv. Cost neutral legislation
      v. Annual fee schedule increases of 0.5% only through 2019
      vi. Bundles PQRS, MU, VBM
      vii. Goals of MACRA from CMS:
         1. Design a patient-centered approach leading to better, smarter, and healthier care;
         2. Develop a program that is meaningful, understandable, and flexible for clinicians;
3. Design incentives that drive delivery system reform principles and participation in APMs; and
4. Ensure attention to excellence in implementation, effective communication, and operational feasibility
b. Merit Based Incentive Payment System (MIPS)
   i. Combination of MU, PQRs, VM, and new CPIA
c. Quality Payment Program (QPP) - the overarching name that covers MIPS and APM tracks
d. MIPS Composite Performance Score (CPS)
5. What is Value Based Purchasing?
6. What happens to the Medicare Fee Schedule?
   a. Medicare payments will increase 0.5 annually from 2017 to 2019
   b. From 2020 to 2025, the fee schedule will be frozen
   c. In 2026, the fee schedule will begin to wind back up with 0.25 increases annually for MIPS and 0.75 for those who participate with Alternative Payment Models (APMs)
7. The Four Components of MIPS
   a. Quality
      i. What measures should you report?
   b. Clinical Performance Improvement Activities (CPIA)
      i. Definitions, Expectations, and Examples
      ii. Base Score, Performance Score, Bonus Options
c. Advancing Care Information (CPIA)
   i. Definitions, Expectations and Examples
d. Cost
8. MIPS Time Frame
   a. 2017 is a Transition Year
   b. Four (4) Reporting Options
      i. Option 1 – Report some data:
         1. Clinicians can choose to report some data such as one measure in the quality performance category; one activity in the improvement activities performance category; or report the required measures of the advancing care information performance category and avoid a negative MIPS payment adjustment.
         2. If MIPS eligible clinicians choose to not report even one measure or activity, they will receive the full negative 4% adjustment.
      ii. Option 2 – Report for a period of time less than the full year performance period 2017 but for a full 90-day period at a minimum:
         1. Clinicians will report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information performance category in order to avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment.
iii. Option 3 – Report for the year:
   1. Clinicians can choose to report to MIPS for a full 90-day period or, ideally, the full year and maximize the clinician’s chances to qualify for a positive adjustment.

iv. Option 4 – MIPS eligible clinicians can participate in Advanced APMs, and if they receive a sufficient portion of their Medicare payments or see a sufficient portion of their Medicare patients through the Advanced APM, they will qualify for a 5 percent bonus incentive payment in 2019.

9. MIPS Penalties and Rewards
10. MIPS Participation and Exclusions
   a. Group vs. Individual Reporting
11. Composite Scores
   a. What is it?
   b. How does it affect reimbursement?
12. Assessing and Understanding Your Quality Reports (QRUC)
13. What happened to Meaningful Use and the “Value-Based” Modifier?
14. Reporting Methods
15. How will Registries be used to access data?
16. CMS providers Quality Resource and Use reports (QRURs)
   a. Assessing these reports
   b. Interpreting these reports
17. Bundled Payments
   a. What are they?
   b. How will they affect your reimbursement?
18. What are “Alternative Payment Models”?
19. What should you do now to get prepared?
20. Questions and Answers