**Questions from MACRA Webinar**

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| 1. Just to clarify, right now this is just Medicare, right?   MACRA only involves Medicare.  However, it is anticipated that the quality measures tied to MACRA will become standard across payers.  In addition, movement into APMs is expected to push the private payers toward value-based pricing. |
| 1. Do you think this type of reimbursement program with will be adopted by private insures?   See Above. |
| 1. Should it be AAPM participants are free of MIPS reporting rather than APMs?   Yes, AAPMs are free from MIPS reporting, but must meet other standards. APMs must fulfill these  requirements:   * Requires participants to use certified EHR technology * Bases payment on quality measures comparable to those in the MIPS Quality performance   category   * Either APM entities must bear more than nominal financial risk for monetary losses, or   the APM is a Medical Home Model expanded by the CMS Innovation Center  Providers in AAPMS must meet specific volume or payment thresholds to qualify.  In 209, these begin with 25% of all Medicare payments being derived from the AAPM.    The MACRA rule lists the following CMS programs as Advanced APMs\*:   * Next Generation ACO Model * Comprehensive ESDR Care (CEC) (large dialysis organization arrangement) * Comprehensive Primary Care Plus (CPC+) * Oncology Care Model (OCM) (two-sided risk track available in 2018)   Clinicians or groups that participate in Advanced Alternative Payment Models, as defined by CMS, and  are able to convert a large enough share of their Medicare and/or other payer reimbursement to  risk-based payment models, will earn a 5% annual payment bump from 2019-2024. |
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| 1. Are Quality Scores based on individual doctors or group practices?   Under MIPS, clinicians can submit performance data as an individual, a group, or an APM entity.  However, they must report the same way across all four categories. Please note that final rule does  allow small and rural practices to form virtual groups to better position themselves to receive MIPS  bonuses.​ |
| 1. In your example of stress testing that fails AUC, who takes the "hit", the ordering provider, the cardiologist   performing / billing the test or both? – don’t have access to presentation.  In general, the ‘hit’ for any quality metric is falls to anyone who is defined as a continuing provider  for the patient. Now that the final MACRA rule is available, ASE will produce a guide outlining  specifics for successful quality reporting. |
| 1. Where can I find a list of all the available quality measures?   Click [here](https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf) for the link to the final MACRA rule in the Federal Register 11/4/16.  The approved cardiovascular quality measures are listed on pages 2237-2242.  A PDF of CV quality measures is available on the ASE Advocacy website. |
| 1. How are they going to have all these options (e.g., checking to see if our EHR can report, finding the right   qualified data registry for our multi-specialty group-do I need a registry for derm, pulmonary, cardiology,  nephrology, primary care, etc.?) set up by 1/1/17?  CMS has stated they are prepared for the program to start running on January 1, 2017.  If you’ve been reporting in the current PRQS program, MIPS reporting will be very similar. |
| 1. Does being a certified medical home make you an AAPM?   Unfortunately being a certified medical home does not make you an AAPM. However, Medical homes  do automatically receive full credit in the Clinical Practice Improvement Activities category of MIPS.  Please note, this only includes medical homes that are accredited by the Accreditation Association for  Ambulatory Health Care, the National Committee for Quality Assurance (NCQA) PCMH recognition,  The Joint Commission Designation, or the Utilization Review Accreditation Commission (URAC).  Clinicians participating in Medicaid Medical Home models will also receive a favorable scoring under  the CPIA category of the MIPS. |
| 1. So many times we are repeating echocardiograms from other facilities that have done a poor job - if our   repeat echo is done within 6 months of the other we are penalized reimbursement because we did the  "second" exam ( which is much more complete) and the first facility that produces a poor exam get FULL  reimbursement. How is this small area (of the BIG picture) of your presentation being evaluated? |
| There isn’t a simple answer, except to say that by putting total cost of care into the equation and  Attributing that cost to the provider who either performed the procedure or delivered the  Plurality of care, providers will begin to organize across the continuum of care to reduce  Inefficiencies, like the one you describe. |
| 1. The facilities the striving to be recognized as a "Center of Excellence" will this be part of the quality   measures? |
| Currently MACRA does not recognized as a "Center of Excellence" as part of the quality  measures. |
| 1. Can MIPS be done without EHR?   Yes, clinicians can comply with MIPs without an EHR, however will not be eligible for any of  the points under the ACI performance category. Reporting without EHR is more burdensome  but is possible through claims or qualified registry. Use of the qualified registry option would  require a manual data collection process. This would require reporting on at least 50 percent of  the clinician’s denominator-eligible patients. |
| 1. How important will ICAEL accreditation be for medical centers or health systems?   Our colleagues at IAC inform us that they are working closely with CMS in order to have  IAC:Echocardiography accreditation count towards the Clinical Practice Improvement  Activities portion of MIPS. This will have a direct impact.  Participation in accreditation is intended to improve clinical quality, which should serve to  Lower total cost of care. Regarding MACRA, this ‘indirect’ benefit of participating in accreditation  Extend to both the AAPM and MIPS environments. |