

AAHAM

American Association of Healthcare
Administrative Management

Spring 2017

THE TEXAS

AMERICAN ASSOCIATION OF HEALTHCARE ADMINISTRATIVE MANAGEMENT
TEXAS BLUEBONNET CHAPTER

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AAHAM
LEGISLATIVE DAY

MAY 1-2, 2017

HYATT REGENCY WASHINGTON ON CAPITOL HILL
WASHINGTON, D.C.



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MEMBERSHIP RENEWAL

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THANK YOU

The Texas Bluebonnet AAHAM Chapter would like to sincerely thank our Corporate Partners for their continued support and dedication to the Chapter. Your partnership enables us to provide quality educational and networking opportunities throughout the year. As we continue to grow as a chapter, please know that partnerships with our sponsors are vital to our success. We are undeniably grateful to you for your enthusiastic support.

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WELCOME

National News: www.aaham.org

The 2017 Legislative Day will be held at the Hyatt Regency Washington on Capitol Hill, Washington, D.C. from May 1-2, 2017.

There is Plenty to Talk About...

2017 marks the thirteenth year AAHAM has brought members together with their elected officials at the AAHAM Legislative Day. We need your support to make sure our voices are heard.

Bring others from your chapter as well as from your facility AAHAM encourages you to bring other chapter members and coworkers along for this fantastic learning experience.

[Click here for more information and to register.](#)

Be A Speaker!

We are inviting you to become a part of the American Association of Healthcare Administrative Management (AAHAM) speaker's tradition. AAHAM is accepting proposals to speak on our Webinars or to be added to our Speaker Database. You are not required to be an AAHAM member to submit a program proposal.

AAHAM is the source of education and information to thousands of patient financial services professionals across the United States since the 1970's. By being an AAHAM speaker, you have the opportunity to impact individuals driven to improve themselves, their place of work, AAHAM, the industry and the nation. Your experiences and insights are in demand... here is your chance to share your expertise and knowledge and to give back to the industry you are committed to.

Webinars

Webinars are 90 minute telephone conference calls that include a presentation, a Q&A period (if time permits) and an optional electronic handout to provide to participants via e-mail. This format allows an unlimited amount of people to listen in from one room. Topics should include anything that is a pressing issue for patient financial services professionals or that would provide participants with information to better themselves and their career. Proposals for webinars may be submitted at anytime. We appreciate that speakers agreeing to present an audio conference agree to waive compensation.

To submit your proposal, please [click here to complete the online submission form.](#)

Become
an AAHAM
Corporate
Partner

Has your company explored the benefits of becoming an AAHAM Corporate Partner yet?

Several levels of memberships are available and benefits include: ad placements, complimentary meeting registrations, signage, website logo/link, logo on ASI brochure and much more!

CLICK HERE for more info.

Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program



For more information visit www.CMS.gov

Provider Types Affected

This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in original Medicare or a Medicare Advantage plan.

What You Need to Know

STOP – Impact to You

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing (such charges are known as “balance billing”). QMB is a Medicare Savings Program that exempts Medicare beneficiaries from Medicare cost-sharing liability.

CAUTION – What You Need to Know

The QMB program is a State Medicaid benefit that covers Medicare deductibles, coinsurance, and copayments, subject to State payment limits. (States may limit their liability to providers for Medicare deductibles, coinsurance and copayments under certain circumstances.) Medicare providers may not balance bill QMB individuals for Medicare cost-sharing, regardless of whether the State reimburses providers for the full Medicare cost-sharing amounts. Further, all original Medicare and MA providers --not only those that accept Medicaid--must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately balance bill QMB individuals are subject to sanctions.

GO – What You Need to Do

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure

that you and your staffs are aware of the federal balance billing law and policies regarding QMB individuals. Contact the Medicaid Agency in the States in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a Medicare Advantage provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments. This practice is known as “balance billing.”

Balance Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers from balance billing a QMB beneficiary under any circumstances. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. (Please note, this section of the Act is available at http://www.ssa.gov/OP_Home/ssact/title19/1902.htm on the Internet.)

QMB is a Medicaid program for Medicare beneficiaries that exempts them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. However, as permitted by federal law, States can limit provider reimbursement for

Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.)

Inappropriate Balance Billing Persists

Despite federal law, erroneous balance billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. See Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015 at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf on the CMS website.

Important Clarifications Concerning QMB Balance Billing Law

Be aware of the following policy clarifications to ensure compliance with QMB balance billing requirements. First, know that all original Medicare and MA providers-- not only those that accept Medicaid-- must abide by the balance billing prohibitions.

continued from page 3

In addition, QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient's QMB benefit is provided by a different State than the State in which care is rendered.

Finally, note that QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the "State Medicaid Manual," which is no longer in effect.

Ways to Improve Processes Related to QMBs

Proactive steps to identify QMB individuals you serve and to communicate with State Medicaid Agencies (and Medicare Advantage plans if applicable), can promote compliance with QMB balance billing prohibitions.

1. Determine effective means to identify QMB individuals among your patients. Find out what cards are issued to QMB individuals so you can in turn ask all your patients if they have them. Learn if you can query state systems to verify QMB enrollment among your patients. If you are a Medicare Advantage provider contact the plan to determine how to identify the plan's QMB enrollees.

2. Discern what billing processes apply to seek reimbursement for Medicare cost-sharing from the States in which you operate. Different processes may apply to original Medicare and MA services provided to QMB beneficiaries. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

If a claim is automatically crossed over to another payer, such as

Medicaid, it is customarily noted on the Medicare Remittance Advice.

Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider

Registration Process and be entered into the State payment system to bill the State.

3. Make sure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts..

Dual Eligibility Qualified Medicare Beneficiary (QMB only)	Eligibility Criteria Resources cannot exceed \$7,280 for a single individual or \$10,930 in 2015 for an individual living with a spouse and no other dependents. Income cannot exceed 100% of the Federal Poverty Level (FPL) +\$20 (\$1,001/month – Individual \$1,348/month – Couple in 2015). Note: These guidelines are a federal floor. Under Section 1902 (r)(2) of the Social Security Act, states can effectively raise these limits above these baseline federal standards.	Benefits Medicaid Pays Medicare Part A and B premiums, deductibles, co-insurance and co-pays to the extent required by the State Medicaid Plan. Exempts beneficiaries from Medicare cost-sharing charges The State may choose to pay the Medicare Advantage (Part C) premium.
QMB Plus	Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage.	Provides all benefits available to QMBs, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient.

Additional Information

For more information about dual eligible categories and benefits, please visit <http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf> on the Internet. Also, for more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the Medicare Learning Network® publication titled "Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles)," which is available on the CMS website.

For general Medicaid information, please visit the Medicaid webpage at <http://www.medicare.gov/index.html> on the CMS website.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association. All rights reserved.

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Thank you to our Chapter Leadership!

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WHAT'S NEW WITH MIPS!! See below for MIPS words!!

By TMF Quality Innovation Network www.TMFQIN.org

Merit-based Incentive Payment System, 2017 Transition Year

The Quality Payment Program (QPP) was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and requires eligible physicians and clinicians to participate in one of two payment paths: the Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Models.

The MIPS program contains four performance categories: Quality, Improvement Activities, Advancing Care Information and Cost. The first year of QPP, 2017, is a transition year.

EMERGING CONTENT

1 MIPS Fact Sheet: Advancing Care Information

Quality Payment Program, Value-Based Improvement and Outcomes

This fact sheet provides a detailed overview of the Advancing Care Information performance category of the Merit-based Incentive Payment System (MIPS).

2 MIPS Fact Sheet: Cost

Quality Payment Program, Value-Based Improvement and Outcomes

This fact sheet provides a detailed overview of the Cost performance category of the Merit-based Incentive Payment System (MIPS).

3 MIPS Fact Sheet: Improvement Activities

Quality Payment Program, Value-Based Improvement and Outcomes

This fact sheet provides a detailed overview of the Improvement Activities performance category of the Merit-based Incentive Payment System (MIPS).

4 MIPS Fact Sheet: Quality

Quality Payment Program, Value-Based Improvement and Outcomes

This fact sheet provides a detailed overview of the Quality performance category of the Merit-based Incentive Payment System (MIPS).

5 Quality Reporting Program Updates—March 31, 2017

Value-Based Improvement and Outcomes

Download this document to read the latest quality reporting updates for the week of March 31, 2017. Learn about reporting updates for physicians and ambulatory surgical centers.

AAHAM CALENDAR

WEBINARS

May 17, 2017
1:30 - 3:00 pm EST
Conscious Communications: Words that Work

May 18, 2017
1:30 - 3:00 pm
CRCS Study Webinar

June 7, 2017
1:30 - 3:00 pm
CRCP Study Webinar - Patient Access Section

June 21, 2017
1:30 - 3:00 pm
CRCP Study Webinar - Billing Section

June 28, 2017
1:30 - 3:00 pm
CRCP Study Webinar - Credit & Collections Section

CERTIFICATION EXAMS

April 17, 2017
Registration Deadline
for July 2017 Certification Exams

August 15, 2017
Registration deadline for Nov. 2017 Exam Period

November 6-17, 2017
November 2017 Exam Period

December 15, 2017
Registration deadline for March 2018 Exam Period

2017 LEGISLATIVE DAY MAY 1-2, 2017

Hyatt Regency Washington
on Capitol Hill,
Washington, D.C.

2017 ANNUAL NATIONAL INSTITUTE
October 18-20, 2017
Opryland Resort
Nashville, Tennessee

CONGRATULATIONS

AAHAM would like to extend its congratulations to the following professionals who passed the March 2017 Certification Exams.

Deidra Gordon	CRCS-I
Deshae-Aleur Jackson	CRCS-I
Mary Johnson	CRCP-P
Tiffany Keogh	CRCS-I
Heather Nash	CRCS-I
Virginia Rodriguez	CRCS-I
Amber Sawyers	CRCS-P
Enrique Serna III	CRCS-I
Martha Walker	CRCS-I
Nikki Weaver	CRCS-I

CRCP exams can be proctored by a CRCP, CRCE or anyone who holds a current management position or works in Human Resources. A proctor cannot be the examinee's supervisor or subordinate. CRCS exams can be proctored by a CRCE, CRCP, CRCS, or anyone who holds a current management position or works in Human Resources. A proctor cannot be the examinee's supervisor or subordinate.

[Click Here to Learn More About AAHAM Certification](#)

1 MPS Fact Sheet: Advancing Care Information

Quality Payment Program, Value-Based Improvement and Outcomes

MIPS Money: Transition Year Pace Options

In 2017, you pick your pace for the transition year. Keep in mind that your transition pace will affect your payment adjustment eligibility.

Transition Pace	Reporting Amount	Payment Adjustment
Test pace	Submit some data after Jan. 1, 2017	Neutral or small positive adjustment
Partial year	Report for any 90-day period after Jan. 1, 2017	Small positive adjustment
Full year	Participate fully starting Jan. 1, 2017	Modest positive adjustment

The test pace requires less data submission than the partial or full year participation during the 2017 transition year.

If submitting for the test pace, choose

- One Quality measure OR
- One Improvement Activity OR
- Four or five required (base) Advancing Care Information measures
–Depends on use of the 2014 or 2015 edition of certified electronic health record technology (CEHRT)

If submitting for a partial or full year, for the Advancing Care Information (ACI) category you must submit the required base measure AND performance measures applicable to your practice. Group reporting is available for eligible clinicians sharing a Taxpayer Identification Number (TIN). "Virtual groups" will not be implemented in Year 1 of MIPS.

For a full list of measures, visit <https://qpp.cms.gov/measures/aci>.

MIPS Methods: Options for Data Submission

Whether reporting as an individual or group, you have options for which method you will use to submit your data.

	Individual	Group
Data submission options	<ul style="list-style-type: none"> • Attestation • Qualified Clinical Data Registry (QCDR) • Qualified registry • Electronic health record (EHR) vendor 	<ul style="list-style-type: none"> • Attestation • QCDR • Qualified registry • EHR vendor • CMS Web Interface (groups of 25 or more)

MIPS Methodology: Scoring for Advancing Care Information

The Advancing Care Information performance category is worth **25 percent** of the final MIPS score in the 2017 transition year. The Advancing Care Information score is determined by adding together points earned on the base score (50 points) plus the performance score (up to 90 points) plus any bonus points (up to 15 points). Although the total possible score is 155 percent, the maximum score will be capped at 100 percent. This allows clinicians the flexibility to focus on measures most relevant to them and their practice.

Advancing Care Information Score =

Base Score + Performance Score + Bonus Score

PUBLICATION INFORMATION

The Texas Tumbleweed is published quarterly by the Texas Bluebonnet Chapter of American Association of Healthcare Administrative Management as a communication medium to Chapter members. Opinions expressed in articles are those of the authors and do not necessarily reflect the views of the Texas Bluebonnet Chapter or its members.

Members are encouraged to submit articles and report news of interest to the membership. Contact the chapter editor to obtain deadlines for submitting articles. The editor reserves the right to edit any submission for clarity and length, and to accept or reject any submission. Please send all submissions (articles in MS Word, advertising in .jpg, .pdf, or .tif files) to:

Jocelyn Cox, Publications Chair
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SUBMISSION DEADLINES:

Editions	Publication Date	Advertising	Articles
Winter	January	Jan. 2	Dec. 7
Spring	April	Apr. 1	Mar. 15
Summer	July	Jul. 1	Jun. 15
Fall	October	Oct. 1	Sept. 15

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- Ads cannot be "re-sized".
- Please do not send any graphics or logos embedded in MS Word or Acrobat text files.

Please submit ads to: info@txaaham.org

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VOLUNTEERS WELCOME!

If you want to get more involved in our Chapter's activities, please contact one of the following committee chairpersons, regarding your areas of interest...

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Base Score (worth 50 percent)

Clinicians must submit a numerator/denominator or yes/no response for each of the following required measures. Failure to meet reporting requirements for the base score will result in an ACI performance score of zero. You can visit <https://chpl.healthit.gov/#/search> for help if you are not sure whether you should report with 2014 or 2015 CEHRT measures.

2017 Advancing Care Information Transition Objectives and Measures:	
Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Send a Summary of Care

2017 Advancing Care Information Objectives and Measures: 2015 CEHRT	
Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Send a Summary of Care
Health Information Exchange	Request/Accept a Summary of Care

Performance Score (worth up to 90 percent)

The performance score accounts for 90 points toward the total Advancing Care Information category score. Eligible clinicians (ECs) select the measures that best fit their practice.

Each measure is calculated individually based on performance compared to historical benchmarks.

Each measure is worth 10-20% The percentage score is based on the performance rate for each measure:			
Performance Rate 1-10	1%	Performance Rate 51-60	6%
Performance Rate 11-20	2%	Performance Rate 61-70	7%
Performance Rate 21-30	3%	Performance Rate 71-80	8%
Performance Rate 31-40	4%	Performance Rate 81-90	9%
Performance Rate 41-50	5%	Performance Rate 91-100	10%

Example: If an eligible clinician reports that 75 out of 100 possible patients were included in the Send a Summary of Care Measure, then the performance rate would be 75 percent and earn the provider eight points toward the performance score.

The total performance score is the sum of the individual provider's score on each of the reported measures.

- 2014 CEHRT report up to seven 2017 Advancing Care Information transition measures OR
- 2015 CEHRT report up to nine 2017 Advancing Care Information transition measures

For a full list of measures, visit <https://qpp.cms.gov/measures/aci>.

Bonus Score (worth up to 15 percent)

You can earn bonus points for the ACI category:

- 5 percent for reporting on one or more Public Health and Clinical Data Registry Reporting measure
- 10 percent for using certified electronic health record technology (CEHRT) to report applicable Improvement Activities

Advancing Care Information Flexibility

The ACI category score will be automatically reweighted to zero for hospital-based MIPS clinicians, clinicians who lack face-to-face patient interaction, and certain mid-level clinicians such as nurse practitioners, physician assistants, certified registered nurse anesthetists and clinical nurse specialists.

- Reporting is optional, although if clinicians choose to report, they will be scored.
- Hospital-based MIPS-eligible clinicians qualify for an automatic reweighting of the ACI performance category.

–75 percent or more of Medicare services performed in the inpatient, on-campus outpatient department or emergency department (point of service 21, 22, 23)

A clinician can apply to have the ACI category score reweighted to zero and the 25 percent will be assigned to the Quality category for the following reasons:

- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of a CEHRT

For more details, visit the CMS QPP webpage at <https://qpp.cms.gov/measures/aci>

2 MIPS Fact Sheet: Cost

Quality Payment Program, Value-Based Improvement and Outcomes

MIPS Momentum: Phasing in the Cost Category

In 2017, the Cost performance category is worth zero percent of the final score. In 2018, the cost performance category is 10 percent of the final score. In 2019 and beyond, the cost performance category will make up 30 percent of the final score as required by MACRA. Although this category will not count in the final score in 2017, the Centers for Medicare & Medicaid Services (CMS) will calculate scores on the cost measures and provide that information to physicians for transition year 2017 as a reference point.

Phasing in Cost - Percentage of Final Score by Year



MIPS Methods: How Cost Is Calculated

Cost measures are based on services delivered; the clinician does not select which ones to report.

- Clinicians are assessed through Medicare claims data. Data submission is thus accomplished automatically, as the necessary Cost category information is extracted from regular Medicare claims submission.
- For a measure to be applied, a clinician must do one of the following:
 - Bill for certain attributable services
 - »Example: Aortic valve replacement
 - Provide services a minimum number of times
 - »35 or more times for Medicare Spending Per Beneficiary (MSPB)
 - »20 or more times for all other measures

The episode group for attributable services includes 10 measures:

- Aortic/mitral valve surgery
- Cholecystectomy and common duct exploration
- Colonoscopy
- Coronary artery bypass graft (CABG)
- Hip replacement or repair
- Inpatient hip/femur fracture or dislocation treatment
- Knee arthroplasty (replacement)
- Lens and cataract procedure
- Mastectomy for breast cancer
- Transurethral resection of the prostate

MIPS Methodology: Scoring for Cost

The Cost performance category is worth 0 percent of the final MIPS score in the 2017 transition year. The Cost score is determined by Medicare claims data. Cost will be determined using measures previously used in the Physician Value-based Modifier program or reported in the Quality and Resource Use Report (QRUR). The Cost score is determined by taking the points assigned for score measures, divided by the number of scored measures multiplied by 10 possible points for each measure.

$$\text{Cost Score} = \frac{\text{Point assigned for scored measures}}{10 \times \{\text{Number of scored measures}\}}$$

Clinicians can earn a maximum of 10 points per Cost measure based on performance compared to benchmarks within performance period.

Readjustment Options

- If a clinician only has one Cost measure with a required case minimum, then that measure is scored accordingly and the overall Cost performance category score will be adjusted to reflect that one measure.
- If a clinician does not have any measures meeting the required case minimum, then a Cost score will not be calculated. In this case, the other three performance category scores increase in weight and a weight of zero is assigned to the Cost category.

There will be no bonus points available for the Cost Performance Category.

For more details, visit the CMS Quality Payment Program webpage at <https://qpp.cms.gov>.

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3 MIPS Fact Sheet: Improvement Activities

Quality Payment Program, Value-Based Improvement and Outcomes

MIPS Money: Transition Year Pace Options

In 2017, you pick your pace for the transition year. Keep in mind that your transition pace will affect your payment adjustment eligibility.

Transition Pace	Reporting Amount	Payment Adjustment
Test pace	Submit some data after Jan. 1, 2017	Neutral or small positive adjustment
Partial year	Report for any 90-day period after Jan. 1, 2017	Small positive adjustment
Full year	Participate fully starting Jan. 1, 2017	Modest positive adjustment

The test pace requires less data submission than the partial or full year participation during the 2017 transition year.

If submitting for the test pace, choose

- One Quality measure OR
- One Improvement Activity OR
- Four or five required Advancing Care Information measures

If submitting for a partial or full year, for the Improvement Activities category you are required to choose one of the following combinations:

- Two high-weighted activities
- One high-weighted activity and two medium-weighted activities
- At least four medium-weighted activities

In 2017, clinicians choose from 90+ activities under nine subcategories. Each category contains the differently weighted activities for you to choose from.

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety and Practice Assessment
- Participation in an APM
- Achieving Health Equity
- Integrating Behavioral and Mental Health
- Emergency Preparedness and Response

Please note: Working with a Quality Innovation Network Quality Improvement Organization (e.g., the TMF QIN-QIO), counts as a medium-weight activity.

Most participants must attest to having completed up to four improvement activities for a minimum of 90 days.

Groups with 15 or fewer participants, or if you are in a rural or health professional shortage area, will attest to having completed up to two activities for a minimum of 90 days.

Participants in certified patient-centered medical homes, comparable specialty practices or an APM designated as a Medical Home Model will automatically earn full credit.

MIPS Methods: Data Submission

Whether reporting as an individual or group, you have options for which method you will use to submit your data..

	Individual	Group
Data submission options	<ul style="list-style-type: none"> • Attestation • Qualified Clinical Data Registry (QCDR) • Qualified registry • Electronic health record (EHR) vendor 	<ul style="list-style-type: none"> • Attestation • QCDR • Qualified registry • EHR vendor • CMS Web Interface (groups of 25 or more)

MIPS Methodology: Scoring for Improvement Activities

The Improvement Activities performance category is worth 15 percent of the final MIPS score in the 2017 transition year.

Improvement Activities Score =

Total number of points scored for completed activities

÷ Total maximum number of points (40)

x 100

Activity weights are worth different point values:

- Medium-weight activities are worth 10 points
- High-weight activities are worth 20 points

Note: For clinicians in small, rural and underserved practices or with non-patient-facing clinicians or groups, the alternate activity weights are as follows:

- Medium-weight activities are worth 20 points
- High-weight activities are worth 40 points

For more details, visit the CMS QPP webpage at <https://qpp.cms.gov/measures/ia>.

4 MIPS Fact Sheet: Quality

Quality Payment Program, Value-Based Improvement and Outcomes

MIPS Money: Transition Year Pace Options

In 2017, you pick your pace for the transition year. Keep in mind that your transition pace will affect your payment adjustment eligibility.

Transition Pace	Reporting Amount	Payment Adjustment
Test pace	Submit some data after Jan. 1, 2017	Neutral or small positive adjustment
Partial year	Report for any consecutive 90-day period after Jan. 1, 2017	Small positive adjustment
Full year	Participate fully starting Jan. 1, 2017	Modest positive adjustment

The test pace requires less data submission than the partial or full year participation during the 2017 transition year.

If submitting for the test pace, choose

- One Quality measure OR
- One Improvement Activity OR
- Four or five required Advancing Care Information measures

If submitting for a partial or full year, for the Quality category you are required to select six of about 300 quality measures. Of these, one must be either

- An outcome measure OR
- A high-priority measure – defined as an outcome measure, appropriate use measure, patient experience, patient safety, efficiency measure or care coordination

Notes:

- You may also select a specialty-specific set of measures.
- Groups using the web interface report 15 Quality measures for a full year.

MIPS Methods: Options for Data Submission

Whether reporting as an individual or group, you have options for which method you will use to submit your data..

	Individual	Group
Data submission options	<ul style="list-style-type: none"> • Qualified Clinical Data Registry (QCDR) • Qualified Registry • Electronic Health Records (EHR) • Claims 	<ul style="list-style-type: none"> • QCDR • Qualified Registry • EHR • Administrative Claims • Centers for Medicare & Medicaid Services (CMS) Web Interface (for groups of 25 or more) • Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

MIPS Methodology: Scoring for Quality

The Quality performance category is worth 60 percent of the final MIPS score in the 2017 transition year. The Quality score is determined by adding together points earned on the required six quality measures and any bonus points, and dividing that total by the maximum number of points. The maximum points equals the number of required measures times 10, and the maximum score cannot exceed 100 percent.

$$\text{Quality Score} = \frac{\text{Points earned on required six quality measures} + \text{Any bonus points}}{\text{Maximum number of points}}$$

How you earn points:

Clinicians receive three to 10 points on each Quality measure based on performance against benchmarks. In the 2017 transition year, participants automatically receive three points for completing and submitting a measure.

- If a measure cannot be reliably scored against a benchmark, then the clinician receives only three points.
- If a measure can be reliably scored against a benchmark, then the clinician could receive up to 10 points. The longer a clinician participates, the easier it is to meet the case-volume criteria needed to receive more than three points.

Failure to submit performance data for a measure equals zero points.

Bonus points can be earned in two ways:

- Submitting an additional high-priority measure
 - Two bonus points for each additional outcome and patient experience measure
 - One bonus point for each additional high-priority measure
- Using Certified Electronic Health Records Technology to submit measures to registries or the Centers for Medicare & Medicaid Services (CMS)
 - One bonus point for submitting this end-to-end electronic reporting

For more details, visit the CMS QPP webpage at <https://qpp.cms.gov/measures/quality>.

5 Quality Reporting Program Updates

Week ending March 31, 2017

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Read the announcements in this document under these sections of content.

- Physician Offices
- Ambulatory Surgical Centers

Are you looking for facility-specific information? Try here:

Ambulatory Surgical Centers

Sign up for your own notifications from the Centers for Medicare & Medicaid Services (CMS). Click on the appropriate tab at the top at: <https://www.qualitynet.org/>

Sign up for further event notifications and resources at <http://www.qualityreportingcenter.com/>

Critical Access Hospitals

Sign up for your own CMS notifications (see tab at the top under Inpatient and Outpatient Hospital) at: <https://www.qualitynet.org/>

Sign up for further event notifications and resources under Inpatient/ Outpatient Hospital at <http://www.qualityreportingcenter.com/>

Inpatient Hospital

Sign up for your own CMS notifications. Click on the appropriate tab at the top at: <https://www.qualitynet.org/> Sign up for further event notifications and resources at the Inpatient Hospital tab <http://www.qualityreportingcenter.com/>

Inpatient Psychiatric Facilities

Sign up for your own CMS notifications. Click on the appropriate tab at the top at: <https://www.qualitynet.org/> Sign up for further event notifications and resources at the Inpatient Hospital tab <http://www.qualityreportingcenter.com/>

Outpatient Hospital

Sign up for your own CMS notifications. Click on the appropriate tab at the top at: <https://www.qualitynet.org/> Sign up for further event notifications and resources at the Outpatient Hospital tab <http://www.qualityreportingcenter.com/>

Physician Offices

Sign up for your own CMS notifications as well as Medicare Learning Network at:

https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_520

PPS-Exempt Cancer Hospital

Sign up for your own CMS notifications. Click on the appropriate tab at the top at: <https://www.qualitynet.org/> Sign up for further event notifications and resources at the Inpatient Hospital tab <http://www.qualityreportingcenter.com/>

[Read more >](#)

2017 Scholarship Application

Deadline May 31, 2017

AAHAM offers scholarship opportunities for our members and dependents of our members.
The application can be downloaded by [clicking here](#) or from the AAHAM homepage..

For more information, please contact Moayad Zahraiddin at moayad@aaaham.org.