MACRA and MIPS: What You Need to Know Now and in 2018

September 20, 2017
MACRA: Medicare Access and CHIP Reauthorization Act
MIPS: Merit-Based Incentive Payment System
Quality Performance
Advancing Care Information
Clinical Practice Improvements
Resources Use
A Physician’s Composite Score

Cost will not factor into your MIPS score for 2017

What are the Performance Category Weights?
Weights assigned to each category based on a 1 to 100 point scale

Transition Year Weights

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
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Note: These are defaults weights; the weights can be adjusted in certain circumstances
Flexible Start for Clinicians: Pick Your Pace

**Participate in an Advanced Alternative Payment Model**
- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

**Test Pace**
- Submit something
- Neutral or small payment adjustment

**MIPS**
- Submit a Partial Year
- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

**Partial Year**
- Submit a Partial Year
- Fully participate starting January 1, 2017
- Modest positive payment adjustment

**Full Year**
- Submit a Full Year
- Part of the transition year will result in a negative 4% payment adjustment.

Don’t have to sign up or tell CMS which you choose
4 options

- **Option one:** “Test Pace”
  As long as you submit some data to the Quality Payment Program, including data from after Jan. 1, you will avoid a negative payment adjustment. This option is intended to ensure that the system is working and that physicians are prepared for broader participation in the coming years as they learn more.

- **Option two:** Partial-year reporting
  Physicians can choose to report Quality Payment Program information for a reduced number (90) of days. Your first performance period could begin well after Jan. 1 and your practice could still qualify for an incentive payment. If you submit information for part of the calendar year for quality measures, how your practice uses technology and what improvement activities your practice is undertaking, you could qualify for a small positive payment adjustment.

- **Option three:** Full-year reporting
  If your practice is ready to get started on Jan. 1, you can choose to report Quality Payment Program information for the full calendar year. Your first performance period would begin on Jan. 1, and if you submit information for the entire year your practice could qualify for a modest positive payment. Your data for 2017, must be submitted by 3/31/2018.

- **Advanced Alternative Payment Model (APM) option**
  This option is still available and qualified participants in advanced APMs will be eligible for five percent incentive payments in 2019.
MIPS: Choosing to Test for 2017

- Submit minimum amount of 2017 data to Medicare
- Avoid a downward adjustment

You Have Asked: “What is a minimum amount of data?”

1. Quality Measure
2. Improvement Activity
4 or 5 Required Advancing Care Information Measures
MIPS: Partial Participation for 2017

- Submit 90 days of 2017 data to Medicare
- May earn a positive payment adjustment

“So what?” - If you’re not ready on January 1, you can start anytime between January 1 and October 2

JAN 1

Oct 2

Need to send performance data by March 31, 2018
MIPS: Full Participation for 2017

- Submit a full year of 2017 data to Medicare
- May earn a positive payment adjustment
- Best way to earn largest payment adjustment is to submit data on all MIPS performance categories

Key Takeaway:
Positive adjustments are based on the performance data on the performance information submitted, not the amount of information or length of time submitted.
Quality Payment Program

Individual vs. Group Reporting

OPTIONS

Individual

1. Individual—under an NPI number and TIN where they reassign benefits

Group

2. As a Group
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

* If clinicians participate as a group, they are assessed as group across all 4 MIPS performance categories
Things to remember

- Choosing any of the options (test, partial or full year) guarantees that you will not receive a negative payment adjustment (penalty). If you do nothing, it will ensure a 4% negative payment adjustment.
- Your participation in MACRA in 2017 will affect your 2019 fee schedule.
- Your penalty or bonus can be as high – or low – as 4% in 2019.
- In 2022 penalties/Bonuses can be as high – or low as 9%.
- You may be able to claim the exclusion from MIPS.
Exclusions

Medicare will look at 2 different period to determine if you are a low-volume provider:
9/1/15 – 8/31/16 or 9/1/16 – 8/31/17
MIPS Performance Category: Quality

- Category Requirements
  - Replaces PQRS and Quality Portion of the Value Modifier
  - “So what?”—Provides for an easier transition due to familiarity

60% of final score

Select 5 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:
- Outcome measure OR
- High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

Different requirements for groups reporting CMS Web Interface or those in MIPS APMs

May also select specialty-specific set of measures

Readmission measure for group submissions that have ≥ 16 clinicians and a sufficient number of cases (no requirement to submit)
Quality Performance (60%) of your total score (Max 80-90 total points can be earned)

- Replaces PQRS
- Report **6** quality measures (down from 9 in PQRS),
  - One must be an outcome measure or a high priority measure for a minimum of 90 days.
- All measures must be reported in the same fashion
- Certain measures can be reported via claims **and** registry. Certain measures can **only** be done via registry.
- There is a difference between performing the measure and reporting the measure.
Performing vs. Reporting

Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

- **Performance Met:** Normal blood pressure reading documented, follow-up not required *(G8783)*

  OR

- **Performance Met:** Pre-Hypertensive or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented *(G8950)*

  OR

- **Denominator Exception:** Documented reason for not screening or recommending a follow-up for high blood pressure *(G9745)*

  OR

- **Performance Not Met:** Blood pressure reading not documented, reason not given *(G8785)*

  OR

- **Performance Not Met:** Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given *(G8952)*
Claims vs. Registry reporting

- Claims Measures
  - 50% of Medicare Part B patients
  - Measures must be submitted at the time of the encounter

- Registry Measures
  - 50% or more of all patients, including private carriers
  - Can go back and collect data after the date of service

Remember: All 6 measures must be by the same submission method
Advancing Care Information Requirements for the Transition Year

Test pace means...
- Submitting 4 or 5 base score measures
  - Depends on use of 2014 or 2015 Edition
- Reporting all required measures in the base score to earn any credit in the advancing care information performance category

Partial and full participation means...
- Submitting more than the base score in year 1

For a full list of measures, please visit qpp.cms.gov
Advancing Care Information (25%) of your total score (Max 100 points can be earned)

- Replaces Meaningful Use
- Report base measures and optional measures
- More flexible reporting than current MU
- Not pass/fail, but graduated scoring, starting with a base score
Advancing Care Information (25%) of your total score (Scoring more than 100 points will earn you full credit)

- A provider **must** report on all the **required** measures just to ensure their base score of 50

- A provider would need to report on more than the required measures for partial or full participation
MIPS Performance Category: Advancing Care Information

BASE SCORE + PERFORMANCE SCORE + BONUS SCORE = FINAL SCORE

- Account for 50% of the total Advancing Care Information Performance Category Score
- Account for up to 90% of the total Advancing Care Information Performance Category Score
- Account for up to 15% of the total Advancing Care Information Performance Category Score

Earn 100 or more percent and receive FULL 25 points of the total Advancing Care Information Performance Category Final Score

The overall Advancing Care Information score would be made up of a base score, a performance score, and a bonus score for a maximum score of 100 percentage points.
MIPS Performance Category: Advancing Care Information

- Clinicians must use certified EHR technology to report

For those using EHR Certified to the 2015 Edition:

- **Option 1**
  Advancing Care Information Objectives and Measures

- **Option 2**
  Combination of the two measure sets

For those using 2014 Certified EHR Technology:

- **Option 1**
  2017 Advancing Care Information Transition Objectives and Measures

- **Option 2**
  Combination of the two measure sets
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## MIPS Performance Category: Advancing Care Information

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Advancing Care Information: 2014 vs. 2015 certification

MIPS Performance Category: Advancing Care Information

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Clinical Practice Improvement (15%) of your total score (Max 60 points can be earned)

- New Category
- Based on things such as same-day appointments, timely communication of test results, establishing care plans, after hours access to clinician advice
- Will most likely be submitted via attestation
MIPS Performance Category: Improvement Activities

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access

- Clinicians choose from 90+ activities under 9 subcategories:
  1. Expanded Practice Access
  2. Population Management
  3. Care Coordination
  4. Beneficiary Engagement
  5. Patient Safety and Practice Assessment
  6. Participation in an APM
  7. Achieving Health Equity
  8. Integrating Behavioral and Mental Health
  9. Emergency Preparedness and Response
Quality Payment Program

Improvement Activity Requirements for the Transition Year

Test Pace means...
- Submitting 1 improvement activity
  - Activity can be high weight or medium weight

Partial and full participation means...
- Choosing 1 of the following combinations:
  - 2 high-weighted activities
  - 1 high-weighted activity and 2 medium-weighted activities
  - At least 4 medium-weighted activities
Clinical Practice Improvement (15%) of your total score (Max 60 points can be earned)

Some high weight measures are:

1. Provide 24/7 access to eligible clinicians or groups who have real-time access to patient’s medical record
   - Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.

2. Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
   - Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.

3. Consultation of the Prescription Drug Monitoring program
   - Clinicians would attest that, 60 percent for first year, or 75 percent for the second year, of consultation of prescription drug monitoring program prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription that lasts for longer than 3 days.
Some medium weight measures are:

1. **Annual registration in the prescription drug monitoring program**
   - Annual registration by eligible clinician or group in the prescription drug monitoring program of the state where they practice. Activities that simply involve registration are NOT SUFFICIENT. MIPS eligible clinicians and groups must participate for a minimum of 6 months.

2. **Implementation of fall screening and assessment programs**
   - Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (e.g., Clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk).

3. **Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms**
   - Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.

4. **Use of decision support and standardized treatment protocols**
   - Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.
5. Implementation of use of specialists reports back to referring clinician or group to close the referral loop
   - Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the certified EHR technology.

6. Collection and use of patient experience and satisfaction data on access
   - Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.

7. Engagement of community for health status improvement
   - Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist MIPS eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.

8. Engagement of patients, family and caregivers in developing a plan of care
   - Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified EHR technology.
MIPS Performance Category: Cost

- No reporting requirement; 0% of final score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.

Keep in mind:

- Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)
- Only the scoring is different
MIPS Changes for 2018

- Raising the low-volume threshold to exclude individual MIPS eligible clinicians or groups who bill ≤ $90,000 Part B billing OR provide care ≤ 200 Part B enrolled beneficiaries
  - Opt-in option
- Quality Performance Category
  - Increasing the data completeness threshold, process to cap and then eliminate topped out measures
- Cost
  - Remaining at 0%
- Improvement
  - Remain @ 15%
- Whether the performance threshold should be set at a level other than 15 points
  - Possibly 6 or 33 points
Raising the low-volume threshold to exclude individual MIPS eligible clinicians or groups who bill ≤ $90,000 Part B billing OR provide care ≤ 200 Part B enrolled beneficiaries

- Individuals may voluntarily participate in MIPS but would not be subject to MIPS payment adjustments
Exclusions

- Newly enrolled in Medicare
- Below low-volume thresholds
- Participate in APM
Performance Period

- Consecutive 90 day period for quality, advancing care information and Improvement activities
- 12 month calendar year for cost
- The cost category will still be 0%, for the next year and clinicians don’t need to report on this category
Performance Threshold (Proposed)

- 15 points (minimum)
- Additional performance threshold remains at 70 points for exceptional performance
- Payment adjustment for 2020 MIPS payment year ranges from -5% to + (5% x 3 scaling factor)

**How to achieve 15 points**

- Meet ACI base score and submit 1 quality measure that meets data completeness
- Meet the ACI base score by reporting the 5 base measures and submit one medium weighted improvement activities
- Submit 6 quality measures that meet data completeness criteria
Scoring for MIPS

- 0 points: **negative** payment adjustment of 5%
- 15 points: **neutral** payment adjustment
- 16-69 points: **positive** adjustment
- ≥70 points: positive adjustment **and** eligible for exceptional performance (minimum 0.5%)
Data Submission Methods

- Same in 2018 as in 2017
Multiple submission mechanisms would be allowed as needed to meet requirements of quality, improvement activities or ACI.
Data completeness: same for 2018 (50%) but increase to 60% in 2019. If less than 50% get 1 point instead of 3 points

3 point floor for measures that can't be scored against a benchmark
Topped out Measures

- Cap of 6 points for a select set of 6 topped out measures
- After 3 years, removal of certain measures
Cost

- Will still be set at 0% and not contribute to 2020 score
Improvement Activities

- No change in scoring
- Remains at 15%
- Small practices: 1 high-weight or 2 medium-weight
- Either 2014 or 2015 certified versions, but bonus for use of 2015 certified version
- Add more improvement activities to list for ACI bonus
- For 5% bonus, different registries
- Re-weight to 0% and move to quality
Scoring Improvement

- Quality
  - Improvement at performance category: CMS will look at rate of improvement
  - Up to 10 points available for improvement

- Cost
  - Although the percentage will continue to be 0 in 2020, CMS will look at statistically significant changes at the measure level
15 clinicians or less: automatic 5 bonus points so long as the clinician submits data on at least 1 performance category during the performance period
Additional Scoring Information

- If you qualify, reweighting of ACI to Quality
- Add 5 point for small
- 10 points for 2015 certified EHR