Navigating Payment Reform: Understanding MACRA-MIPS

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2017 Government Changes

- Medicare Legislative & Payment Model Changes
- Quality Program Changes (PQRS)
- Value Based Payment Modifier (VBM)
- Electronic Health Record / Meaningful Use Program Changes (MU)
- Merit Based Incentive Program Changes (MIPS)

2017 Government Changes to Fees

- Medicare Deductible – part B is $183 for 2017
- Medicare Part B standard monthly premium is $134
  - 10% increase from 2016 premium of $121.80
  - For filers with <$85,000 income
  - Higher income have higher premiums, up to $428.60
    - Affects 5% of people with Medicare
- Social Security Administration announced a COLA of 0.3% for 2017

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MACRA for 2017 is Here

- Protecting Access to Medicare Act (PAMA) 2014
  - RVU changes occurred Jan. 1, 2015
    - 1-4% reduction across most codes
  - Sequestration continues through 2023 with 2% reduction in Medicare payments
- Medicare Access & CHIP Reauthorization Act 2015
  - Repeals the SGR, preventing 21% cuts in MPFS
  - Provides 5 years of 0.5% positive updates in MPFS
  - Conversion factor increases 0.5% 2016-2019
  - Conversion factor increases 0% in 2020-2025

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2017 MACRA Quality Program Changes

- Medicare Access & CHIP Reauthorization Act of 2015
  - Consolidation of existing quality programs into new program called Merit Based Incentive Payment System (MIPS) in 2019
    - PQRS, EHR Meaningful Use, and Value Based Payment Modifier
  - Penalties linked to current quality programs sun-set after 2018
  - Extends Children's Health Insurance Program (CHIP) for 2 years

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Government Projections – FFS Cuts

- 2016 – 54 million beneficiaries / -$25B projected cut
- 2017 – 59 million beneficiaries / -$32B projected cut
- 2018 – 61 million beneficiaries / -$42B projected cut
- 2019 – 63 million beneficiaries / -$53B projected cut
- 2020 – 64 million beneficiaries / -$64B projected cut
- Source: CMS 2013 Annual Report – projected Medicare FFS payment cuts per ACA
- CY 2015 MC A & B provider payments of $371B
- CY 2015 MC D payments of $85B

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Evolution of Payment Models

- Category 1 – fee for service with no link of payment to quality
- Category 2 – fee for service with link of payment to quality
- Category 3 – alternative payment models built on fee for service architecture
- Category 4 – population based payment
- Goals are 90% of Medicare FFS payments in Category 2-4 by 2018
- 75% of commercial plans will be value based

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Evolution of Payment Models in HCR

- Principles of Health Care Reform are intended to improve health care quality, engage patients, improve communication between entities, and reduce costs
- Meaningful Use Stage 1 = get hooked up with computers
- Meaningful Use Stage 2 = communication between providers and patients
- Meaningful Stage 3 = Demonstrate improved quality
- Goal is to reward value & care coordination not volume & care duplication

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CMS Incentive Programs

- Physician Quality Reporting System (PQRS)
- Health Information Technology (HIT/EHR)
- Value-Based Payment Modifiers (VM)
  - Aoa.org/vbm-fact-sheet
- Merit-Based Incentive Payment System (MIPS)
  - Starting in 2019, MIPS will combine VBM, PQRS, & EHR/MU; payments will be adjusted accordingly
  - Begin rating doctors based on a 100 point scale reflecting performance on quality, resource use, clinical practice improvement activities & MU of EHR

Physician Value-Based Payment Modifier

- CMS will adjust payment to some physicians based on quality & resource use beginning in 2015 and all physicians by 2017
  - Now applies only to groups of 100 or more (originally 25)
  - Smaller groups (2-99) remain unaffected until 2017
- 2015 applied to payment in groups of 100 or more
- 2016 applied to payments in groups of 10 or more
- 2017 applied to payments in solo or group practices based on service (PQRS/EMR MU) provided in 2015
- Quality tiering will apply to providers that **satisfactorily** report PQRS in 2016

Physician Value-Based Payment Modifier

- Category I - At least 50% of eligible professional within Tax ID met criteria to avoid 2016 PQRS payment penalty adjustment
  - Based on 2014 performance
- Category II - <50% of eligible professionals within Tax ID met PQRS measures and were subject to payment adjustments
  - Additional 2% payment adjustment will apply
- Failure to meet PQRS measures in 2015 may result in 4% payment adjustment

MIPS Payment Adjustments

- Quality Payment Program (QPP) final policy released October 14, 2016
- **Your performance in 2017 affects your bonus or penalty in 2019 for Medicare Part B**
- MIPS payment adjustment
  - 2016-18 = 0
  - 2019 = +/-4%
  - 2020 = +/-5%
  - 2021 = +/-7%
  - 2022 = +/-9%

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MIPS Eligible Providers

- Physicians
- Physician Assistants ((PA)
- Nurse Practitioners (NP)
- Clinical Nurse Specialists (CNS)
- Certified Registered Nurse Anesthetists (CRNA)
- Groups that include such clinicians

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MIPS Eligible Providers

- Next generation ACOs
- Comprehensive Primary Care Plus
- Medicare Shared Savings Program (MSSP)
- Oncology Care Model with two sided risk
- Comprehensive End Stage Renal Disease Care
  - for larger dialysis organizations

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MIPS Transition Flexibility

- CMS allows for flexibility in 2017 reporting
  - Allows providers to avoid penalties for 2019
- MIPS Options for Transition Year (2017)
  - Do Nothing = 4% penalty in 2019
  - Submit "some" data = avoid penalties in 2019
  - Partially participate in MIPS = eligible for small bonuses
  - Fully participate in MIPS = eligible for larger bonuses
- Pick-your-pace transition plan
- Payment adjustment will depend on how much data you submit & your quality results

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MIPS Transition Flexibility

- -% = DON'T PARTICIPATE and receive a -4% reduction
- 0% = TEST by submitting a minimum amt of 2017 data (ex. 1 quality measure or 1 practice improvement activity) thereby avoiding downward payment adjustment
- +% = PARTIAL participation more than 1 quality measure or more than 1 practice improvement activity at any time in 2017 and qualify for a small bonus
- ++% = FULLY participate by submitting 90 days or up to 1 year of 2017 data for moderate bonus

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MIPS Transition Flexibility

- MIPS is budget neutral
- If few providers receive penalties the bonuses would be lower to maintain neutrality with maximum of 4%
- Exceptional performance
  - Providers who fully participate
  - Earn a **MIPS score of 70** or higher
  - Qualifies for additional bonus of 0.5% or higher
    - Capped at 10%
  - Funded by $500 million authorized by law

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Can You Be Excluded from MIPS ?

- If you see 100 or fewer Medicare patients per year or
- If you have $30,000. or less in allowed charges / year
- If you are newly enrolled in Medicare during the reporting year
- If you participate in an Advanced APM that meets the required thresholds

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MIPS Categories for Scoring

- Quality Program Measures (formerly PQRS) = 60%
- Advancing Care Information (formerly EHR/MU) = 25%
- Clinical Practice Improvement Activities = 15%
- Resource Use = 0%
- MIPS Final Score of 100
  - **Final score of 3** will avoid negative payment adjustment
    - Achieved by submitting 1 quality measure or 1 practice improvement activity (CPIA)
  - **Final score of >3 and <70** eligible for small bonus up to 4%
  - **Final score of >70** eligible for additional bonus of at least 0.5% (capped at 10%) from funds for "exceptional performance"

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Quality Payment Program in MIPS

- Report 1 Quality measure at any point during the year
- Can report using Registry, EHR, or Claims
- As little as ***1 measure on one patient*** avoids penalty!
- Eligible to earn Small Bonus – successfully ***report more than 1 measure at any time during the year***
- To Maximize Quality Score – for ***minimum of 90 days***, ***report 6 measures*** using Registry, EHR or claims
  - Report ***on at least 50%*** of applicable patients
    - Medicare only for claims reporting
    - All payers for Registry & EHR reporting
  - 1 measure must be an "Outcome" or "High Priority Measure"

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Quality Program Scoring in MIPS

- Quality Scoring is 60% of MIPS
  - **Each of the 6 measures is worth from 3-10 points** depending upon your success on each measure
  - **Each measure reported will earn a minimum of 3 points**
    - Even if not reported for 90 days
    - Even if not reported on 50% of eligible patients
- Outcomes Measures – **2 bonus points per measure** awarded for additional outcomes measures, when more than one outcomes measure reported
- EHR or Registry-EHR integration – **1 bonus point** awarded for electronically reporting quality measures

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Quality Program Scoring in MIPS

- Outcomes & High Priority Measures by sub-specialty
- Electronic reporters
  - Comp/Cataract – 2 outcomes
  - Comp/Retina – 1 high priority
  - General – 2 outcomes, 4 high priority

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Quality Program Scoring in MIPS

- Outcomes & High Priority Measures by sub-specialty
- Manual reporters
  - Cataract – 4 outcomes
  - Cornea – 1 outcomes
  - Glaucoma – 4 outcomes
  - Neuro – 3 outcomes, 1 high priority
  - Pediatric – 2 outcomes
  - Retina – 6 outcomes, 1 high priority
  - Uveitis – 4 outcomes
  - General – 2 outcomes, 3 high priority

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Quality Program Measures Update

- New & revised 2017 ICD-10 codes now required
- No longer required to report from specific quality domains
- **Required to report from at least one measure that is**
  - **Outcome or High priority**
- Data submission requirement by method
  - Claims reporting – processed within 60 days of end of performance period (March 1, 2018)
- Manual registry reporting – submitted by March 31, 2018
- EHR reporting – submitted by March 31, 2018

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Quality Measures: eCQMs MIPS

- DM: HA1c Poor Control (>9%) – Outcomes
- Closing referral loop: receipt of specialist report – High P
- Documentation of current medications in Record – High P
- Preventive care/screening: BMI screening & F/U
- Pneumonia vaccination status older adults
- DM: eye exam
- Cataracts complication w/in 30D of Sx – Outcomes
- Cataracts: 20/40 or better VA w/in 90 D – Outcomes
- Preventive care/screening for Tobacco Use
- Falls: Screening for Fall Risk – High Priority

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Quality Measures: eCQMs MIPS

- DM: Diabetic retinopathy/Communication w PCP – High
- DM: Presence/absence of ME & level of Diab Retinop
- POAG: Optic Nerve evaluation
- Preventive care / screening: Influenza immunization
- Use of High Risk Medications in elderly – High P
- Controlling Blood Pressure – Outcome

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Quality Measures: Non-EHR MIPS

- DM: HA1c Poor Control – Outcome
- DM: Dilated exam
- DM: diabetic retinopathy communication w PCP – High P
- POAG: Optic nerve eval
- POAG: reduction of IOP by 15% or care plan – Outcomes
- AMD: dilated exam
- AMD: counseling on antioxidant Suppl
- Documentation of current medications in record – High P
- Cataracts: 20/40 or better VA (90 days of Sx) – Outcomes
- Cataract: complication w/in 30D of Sx - Outcomes

Quality Measures: Non-EHR MIPS

- Preventive care/screening: Influenza immunization
- Pneumococcal Vaccination in Elderly
- Melanoma: continuity of care/recall system – High P
- Melanoma: coordination of care – High P
- Melanoma: overutilization of imaging studies- High P
- Cataract surgery: difference betw planned/final ref – Outc
- Cataract surgery: Intra-op comp/cap rup/vit – Outcomes
- Controlling HTN – Outcomes
- Preventive care/screening for HTN
- Tobacco Use /help quitting in adolescents

Quality Measures: Non-EHR MIPS

- Adult primary Rhegma RD repair success rate – Outcome
- Adult primary Rhegma RD Surgery success rate – Outcome
- Biopsy follow up – High Priority
- Overuse of neuroimaging in HA w normal neuro ex – High Priority

Quality Measures: Non-EHR Registry

- POAG: VF progression – Outcome
- POAG: IOP reduction following laser trabec – Outcomes
- Amblyopia: Improvmt VA to 2 or fewer lines – outcome
- AMD: Exudative w Loss of VA – Outcomes
- AMD: Non-exudative w Loss of VA – Outcomes
- AMD: disease progression – Outcomes
- DM: Diabetic macular edema loss VA – Outcomes
- Avoidance of antibiotic treatment in adenovirus – High P
- Corneal graft: 20/40 or better w/in 90 D of Sx – Outcomes
- Surg Esotropia: post-op aligmt of 15PD or less – Outcome

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Quality Measures: Non-EHR Registry

- GCA: absence fellow eye involvmt after steroids – Outco
- Avoidance antibiotic use before /after intravit inj – High P
- Acute Ant Uveitis – post treatmt VA – Outcomes
- Acute Ant Uveitis – post treatmt grade 0 AC cells – Outco
- Chronic Uveitis – post treatmt VA – Outcomes
- Chronic Uveitis – post treatmt grade 0 AC cells – Outcom
- Idiop Intracranial HTN – no worsening – Outcomes
- Oc Myasthenia gravis – improve of deviation/diplopia - Outcomes

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PQRS Incentive Program Update 2017

- reporting on at least 9 measures via claims or registry covering at least 3 Quality Strategy Domains is gone!!
  - Patient Safety / Communication & Care Coordination / Patient/Family experience / Efficiency / Clinical Process & Effectiveness / Community & Population health
- Cross Cutting measures in 2015 still available
- Not participating in PQRS 2016 reduced Medicare reimbursements in 2017 by 2%

PQRS Cross Cutting Measures 2016

- Measure #130 (G8427) – Documentation of current medications in medical record
  - Domain – Patient safety
  - Report via claims, registry, EHR
- Measure #110 (G8482) Influenza immunization: Not w 92xxx
  - Domain – Community & population health
  - Report via claims, registry, EHR
- Measure #111 (4040F) – Pneumococcal vaccination status in >65yo: Not w 92xxx
  - Domain – Community & population health
  - Report via claims, registry, EHR

PQRS Cross Cutting Measures 2016

- Measure #226 Tobacco Use: screening & cessation intervention
  - CPT 4004F – screened for tobacco, received counseling if user
  - CPT 1036F – screened for tobacco, not user
  - Domain – Community & population health
  - Report via claims, registry, EHR, CMG
- Measure #236 – Controlling HTN
  - Domain – Effective clinical care
  - Report via claims, registry, EHR
- Measure #374 – Closing the Referral Loop

PQRS Cross Cutting Measures 2016

- Measure #402 Tobacco Use & help w Quitting among Adolescents
  - Domain – Community & population health
  - Report via EHR
- Measure #128 Preventive Care & Screening BMI
  - Domain - Population Health & Community Health
  - Not w 92xxx
  - CPT 3016F – BMI documented within normal parameters, no f/u

PQRS Measures AOA Recommends

Measure #130 (G8427) – Current medications with name, dose, frequency, route documented, Rx, OTC, Herbals, Multivitamins

- Or G8428 Current medications NOT documented

- Measure #131 (G8730) – Pain Assessment & Follow Up
  - Must use standardized pain assessment tool
  - Must include pharmacologic or educational intervention
  - Or G8509 Not Documented

PQRS Measures AOA Recommends

- Measure #226 (4004F) – Preventive Screening Tobacco Use: Screen and Cessation intervention
  - Report only ONCE per reporting period (24 months)
  - Or 1036 Current Tobacco Non-User
- Measure #317 (G8783) – Preventive Care & screening for High Blood Pressure
  - Must perform BP screening at each visit & document F/U plan
    - Lifestyle modification, Wt Loss, DASH, Less salt, mod EtOH, exercise
  - 2nd HTN reading >140 or >90 w/in 12 months requires Rx, labs, ECG and referral to PCP

PQRS Measures AOA Recommends

- Measure #317 – Preventive Care & screening for High Blood Pressure
  - G8783 – Normal BP documented
  - G8950 - Pre-HTN or HTN Not Documented
  - G8784 – BP Not documented
  - G8951 – Pre-HTN or HTN documented, F/U not documented, patient not eligible
  - G8785 – BP Not documented, reason not given
  - G8952 – Pre-HTN or HTN documented, F/U Not documented, reason not given

Measure 12: POAG Optic N. Evaluation

- CPT category II Code: 2027F
- Diagnosis codes
  - Open angle glaucoma
  - Open angle glaucoma
  - Low tension glaucoma
  - Residual stage of open angle glaucoma
- Documentation tips – ON can be documented with a drawing, description, photograph or scan
- Modifiers -1P, -8P
- Reporting – Claims, registry, EHR (Effective clin care)

Measure 141: POAG Reduction of IOP by 15% or Documentation of Plan of Care

- IOP reduced by 15% from pre-intervention
  - CPT category II Code: 3284F
- IOP reduced less than 15% from pre-intervention
  - CPT category II Code: 3285F plus
  - CPT category II Code: 0517F to document plan of care
    - Recheck IOP, Rx change, additional testing, referral, plan to recheck
- Once per reporting period
- CPT Codes: 92002, 92004, 92014, 92012, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Measure 141: POAG Reduction of IOP by 15% or Documentation of Plan of Care

- Diagnosis codes
  - Open angle glaucoma
  - Open angle glaucoma
  - Low tension glaucoma
  - Residual stage of open angle glaucoma
  - Glaucoma Stage codes
- Modifiers -8P

Measure 14: AMD Dilated Exam

- CPT category II Code: 2019F
- Pts 50yrs+ with diagnosis AMD having DFE with documentation of presence or absence of macular thickening or hemorrhage AND level of severity (mild, moderate, severe) of AMD during one or more office visits w/in 12 mos, minimum of once per reporting period
- Diagnosis codes
  - Macular degeneration, unspecified
  - Non exudative senile macular degeneration (dry)
  - Exudative senile macular degeneration (wet)
- Modifiers -1P, -2P, -8P

Measure 140: AMD Counseling on Antioxidant Supplement

- Patients aged 50 and older with a diagnosis of AMD and/or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD
- CPT category II Code: 4177F
- Diagnosis codes
  - Macular degeneration, unspecified
  - Non exudative senile macular degeneration (dry)
  - Exudative senile macular degeneration (wet)
- Modifiers -8P
- Note: If already receiving AREDS supplements, assumption is counseling has already been performed

Measure 140: AMD Counseling on Antioxidant Supplement

- CPT Codes: 92002, 92004, 92014, 92012, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Measure 117: Diabetes Mellitus Dilated Exam

- CPT category II Code:
  - 2022F: dilated retinal exam by OD/OMD with interpretation documented and reviewed
  - 2024F: 7 standard field stereophotos with interpretation documented and reviewed
  - 2026F: eye imaging validated to match diagnosis from 7 standard field stereophotos with results documented and reviewed
  - 3072F: low risk for retinopathy (no evidence of retinopathy in prior year)
- Modifiers -8P

Measure 117: Diabetes Mellitus Dilated Exam

- Diagnosis Codes
  - DM w/o ophthal manif, type II, not uncontrolled
  - DM w/o complication, type I, not uncontrolled
  - DM w ophthal complications, type II, uncontrolled
  - DM w/o complication, type I, uncontrolled
  - DM w ketoacidosis, type II not uncontrolled
  - DM w ketoacidosis, type I, not uncontrolled
  - DM w ketoacidosis, type II, uncontrolled
  - DM w ketoacidosis, type I, uncontrolled

Measure 18: DM Documentation of Presence of ME & Level of Severity of Retinopathy

- CPT category II Code: 2021F
- Pts 18yrs+ with diagnosis of Diabetic Retinopathy with DFE
- Documentation must include
  - Level of severity of retinopathy (background, non-proliferative (mild, moderate, severe etc), proliferative)
  - If macular edema is present or absent
- Diagnosis codes
  - Background diabetic retinopathy
  - Proliferative diabetic retinopathy
  - Nonproliferative retinopathy, NOS
  - Mild nonproliferative diabetic retinopathy
  - Moderate nonproliferative diabetic retinopathy
  - Severe nonproliferative diabetic retinopathy
- Modifiers -1P, -2P, -8P

Measure 19: Diabetic Retinopathy Communication with Physician Managing Diabetes Care

- CPT category II Code: 5010F (Findings of exam communicated) & G8397 (DFE performed documenting presence or absence of macular edema & level of severity of retinopathy) both required
  - G8398 dilated macular exam not performed
- Patients 18 years+ diagnosed w DR and DFE, at least once per reporting period, documented verbally or by letter
- Diagnosis codes
  - Background diabetic retinopathy
  - Proliferative diabetic retinopathy
  - Nonproliferative retinopathy, NOS
  - Mild nonproliferative diabetic retinopathy
  - Moderate nonproliferative diabetic retinopathy
  - Severe nonproliferative diabetic retinopathy
- Modifiers - -1P added for 2011, all others fine

EHR and MU Changes in MIPS in 2017

- EHR / MU renamed "Advancing Care Information"
- 2017 is a transition year for ACI
- Requires reporting 4 measures to earn ***any*** ACI credit
- Report these 4 measures ***on a single patient*** and you earn ACI credit for the "Base Score"
- Practices can report individually or as a group
- Patient portal measures are ***optional***
  - View, download, transmit and secure messaging
- Scribe certification requirement eliminated
- EHR Information center help desk 888 734 6433 or EHRInquiries@cms.hhs.gov

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EHR and MU Changes in MIPS in 2017

- In 2018 all providers required to upgrade to the 2015 edition of certified EHR technology
  - Allows reporting of 5 measures instead of 4 in 2014 CEHRT
- Hardship exemptions continue in MIPS
  - Category re-weighted to zero and points shifted to Quality score
- Final rule: https://www.federalregister.gov/articles/2015/10/16/2015-25595/medicare-and-Medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications

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Advancing Care Information Scoring

- ACI Score is 25% of MIPS Score
- Total possible Score 155%
  - Base score (50%) – required to earn any credit under ACI
  - Performance score (up to 90%)
  - Bonus score (up to 15%)
- Highest Acheivable score is 100%
  - Scores over 100 will total 100 & earn full 25 points for ACI
- Base score is "All or None" – report each required ACI measure once and get 12.5 points
- Performance score – credit awarded based on achievement level for each measure

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ACI Requirements for Base Score

- Security Risk Analysis – conduct or review a SRA, implement updates, correct identified deficiencies
- Electronic prescribing – at least 1 permissible prescription written is queried for a drug or drug formulary and transmitted electronically using a CEHRT
- Patient Electronic Access: Provide Patient Access – at least 1 unique patient is provided timely access to view online, download and transmit his/her PHI
- Health Information Exchange – at least 1 patient is transitioned or referred to another setting or clinician including creating summary of care and e-exchanged

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ACI Requirmt for Performance Score

- Report these measures to earn performance score based on achievement
  - Patient Electronic Access
    - Provide access – up to 20%
    - View download, transmit – up to 10%
  - Patient Specific Education – up to 10%
  - Secure Messaging – up to 10%
  - Health Information Exchange – up to 20%
  - Medication Reconciliation – up to 10%
  - Immunization Registry Reporting – 0% or 10%

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ACI Requirement for Bonus Score

- Participate in a specialized Registry – 5% bonus score
- Complete a Clinical Practice Improvement Activity (CPIA) using a CEHRT – 10% Bonus Score
  - Ex. Provide 24/7 access to provider for urgent or emergent care or advice
    - Using CEHRT Secure Messaging functionality to provide this care
    - Ex. Sending and responding to secure messages outside of normal business hours

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ACI Objective & Measures for 2017

Protect PHI	Security Risk Anal	Required	0
Electronic Rx	E-prescribing	Required	0
Pt elect access	Provide Pt access	Required	<20
Pt elect access	View downld transm	Not Req	<10
Health info exch	Health info exchan	Required	<20
Secure messag	Secure messaging	Not Req	<10
Meds Reconcil	Meds reconciliation	Not Req	<10
Public health rep	Immunization regis	Not Req	0-10
Public health rep	Syndrome surveill	Not Req	5
Public health rep	specialized registry	Not Req	5
Bonus	CPIA using CEHRT	Not Req	10

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Clinical Practice Improvement in MIPS

- CPIA Scoring is 15% of MIPS Score
- Avoid Penalties – ***attest to completing at least 1 CPI*** activity from list of 90 possible choices
- Earn Small Bonus ***– attest to completing more than 1 CPI activity***
- Earn Full Bonus – ***attest to completing enough CPI activities for a 90 day period to reach 40 points***

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Clinical Practice Improvement in MIPS

- CPI activities are weighted as High or Medium
- High activities – 20 points
- Medium activities – 10 points
- Report on two high, four medium, or a combination to reach 40 points
- For Small practices
  - Points are doubled for practices with less than 15 or fewer eligible clinicians
  - Report on just one high activity to get 40 points or two medium activities

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Clinical Practice Improvement in MIPS

- Must attest to completion of CPIA
- Attestations can be submitted by
  - Using CMS Attestation website
  - Using Registry
  - Using your EHR if offered by your vendor

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Clinical Practice Improvement in MIPS

- High Activities (20 Points)
  - Provision of same or next day care for urgent care needs
  - Provide 24/7 access to physicians for care advise about urgent or emergent care
  - Seeing new or f/u Medicaid patients in timely manner
  - Use of qualified clinical data registry to generate regular feedback reports that summarize practice patterns & treatment outcomes

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Clinical Practice Improvement in MIPS

- Medium Activities (10 Points)
  - Use of qualified clinical data registry data for ongoing practice assessment and improvements in patient safety
  - Participation in registry and use of registry data for quality improvement
  - Provide regular specialist reports back to referring providers
  - Provide self-management materials at an appropriate literacy level and in appropriate language

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Resource Use in MIPS

- Weighted as 0% in 2017
- Will not impact 2017 MIPS Score or 2019 Payment adjustments
- No reporting by doctors required
- Calculated by CMS using administrative claims
- Physicians measured and feedback reports will be provided based on
  - Total per capita cost
  - Medicare spending per beneficiary
  - New episode-based measure: lens and cataract episodes

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Advanced Payment Models in MIPS

- Not all APMs are Advanced APMs
- Advanced APMs must have the following characteristics
  - Bear financial risks
  - Base payments on quality measures
  - All participants must use certified EHR
- Advanced APM Barriers to Entry
  - Thresholds are too high for most doctors to achieve

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Accountable Care Organizations in MIPS

- ACO participants that are not qualifying participants in an Advanced APM are subject to MIPS
  - Includes all Medicare Shared Savings Program ACOs
- MIPS ACO's
  - All participating TINs in a MIPS ACO receive the same MIPS Score
  - Category weightings are different for ACO's
    - Quality measures – 50%
    - Advancing Care Information – 20%
    - Clinical Practice Improvement - 30%
    - Resource Use – 0%

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Scoring Shared Savings ACOs in MIPS

- Quality – Shared savings program ACOs submit quality measures to CMS web interface on behalf of participating eligible clinicians
  - Score: MIPS benchmarks will be used to determine the quality performance category score at the ACO level
  - Weight - 50%
- Cost – MIPS eligible clinicians will not be assessed on cost
  - Score: N/A
  - Weight - 0%

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Scoring Shared Savings ACOs in MIPS

- Improvement activities – ACOs need to report only if the CMS-assigned improvement activities score is below the maximum improvement activities score
  - Score: CMS will assign the same activities score to each APM Entity group based on activates required of participants in Shared Savings Program
  - Minimum score is one half of total possible points
  - If assigned score does not represent the maximum improvement activities score, ACOs will have the opportunity to report additional improvement activities to add points to the APM Entity group score
  - Weight - 20%

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What to Consider to Prepare for MIPS

- Report at least one measure to avoid penalty
- Use 2017 to get ready for 2018-19
- Consider purchase or upgrade of EHR to 2015 CEHRT required in 2018
- Registry – consider integration of your EHR to improve performance rates & scores
- Review your Quality Payment Program feedback report by visiting go.cms.gov/QPP

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Scoring Shared Savings ACOs in MIPS

- Advancing Care Information – all ACOs participant TIN in the ACO submit under this category according to the MIPS group reporting requirements
  - Score – all the ACO participants TIN scores will be aggregated as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score
    - 30%

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Pointers for Planning Your Path Forward

- Using EHR, Using Registry – well positioned for MIPS
  - Submit data for each category and maximize points
- Not using EHR, No PQRS – report 1 quality measure for minimum number of patients (1 or more) or 1 CPIA
  - If successful you avoid penalties
  - Use 2017 as year to evaluate EMR, join registry
- Not going to EHR – can still score potentially high enough to be eligible for bonus if you perform well enough in Quality & CPIA
  - Can apply for hardship exemption

JAM

Pointers for Planning Your Path Forward

- MIPS participants earning composite scores > 3 are eligible for small bonus
- It is possible to earn final scores higher than 3 if reporting on Quality measures (3 patients each) & CPIA
  - Even if not for 90 days
- Via Claims, report 1 patient to avoid penalties, report 6 measures at least 50% of eligible patients to maximize points and be eligible for a bonus
  - Via Claims – on all Medicare patients only
  - Via EHR or Registry – ALL payers

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Pointers for Planning Your Path Forward

- CMS makes it easier to participate in MIPS 2017 so expect lower bonuses to maintain budget neutrality
- Congress authorized $500 M for exceptional performers scoring over 70 points
  - Bonus payments can be 0.5-10%
  - Not subject to budget neutrality
- For Multiple practices, must meet MIPS criteria in each practice (TIN)
- For Non-Par providers in Medicare you can not avoid payment reductions

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Pointers for Planning Your Path Forward

- Group Level reporting is allowed – if practice reports one MIPS category it must do so for all 4.
- Group Level reporting when half the providers do not participate or are not successful will not result in penalties to the entire group in 2017 MIPS
- If in ACO and ACO fails to report MIPS on your behalf you can report yourself at the practice level as a safety back-up plan

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Benefits of Registry Participation

- Helps meet Quality reporting requirements
- Provides at least one Outcome or High Priority Measure to report
- Supports credit for 3 Clinical Practice Improvement Activities (CPIA)
- Facilitates Advanced Care Information reporting by including web entry portal
- Bonus quality points gained by participation in Registry

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AOA MORE Registry aoa.org/MORE

- Measures & Outcomes Registry for Eyecare
- Optometry's new qualified clinical data registry
- Included as AOA member benefit
- AOA MORE EHR Participants
  - Compulink
  - MaximEyes
  - Crystal
  - Practice Director EHR
  - revolutionEHR
  - ExamWRITER

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AOA MORE Registry aoa.org/MORE

- Getting Started
  - Visit AOA.org/MORE, click "enroll" to register
  - Log in and sign terms of agreement
  - Validate educational & professional data
  - Confirm email address and contact information
  - Select practice to enroll
  - Sign business agreement
  - Select EHR
  - Authorize employees to register
  - Submit enrollment

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AOA MORE Registry aoa.org/MORE

- What Do I Do Next ?
  - Continue reporting PQRS data to CMS via claims, EHR, Registry
  - Do this until AOA MORE dashboard shows 50% completion success of all 9 measures

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AOA MORE Registry aoa.org/MORE

- AOA MORE is a data registry, secure, private
- Access statistics derived from your practice database
  - Most common diagnoses, demographics, most common medications prescribed, comparisons to national averages
- AOA can only view aggregate data sent by EHRs
- Requires approved EHR Vendor
- Helps meet Medicare program requirements
- Helps maximize Medicare revenues
- Helps maximize MIPS score

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AOA MORE Registry aoa.org/MORE

- Based on ODs participation in PQRS, CMS expects ODs to Fail under MIPS
- CMS estimates 18,394 ODs subject to MIPS
- CMS estimates 79.7 % of ODs will be penalized under MIPS
  - $21 million loss
- Congress directed CMS to encourage registry use
- AOA MORE is a member benefit at no charge

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How Will You Navigate MIPS?

- Option 1 – report minimum amount of data to avoid penalty
- Option 2 – report enough data to try for small bonus
- Option 3 – report each MIPS category at least 90 days to try for moderate bonus
- Option 4 – Advanced APM
- Option 5 – DO NOTHING, get penalized

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Thank you

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