The Future of How Optometry Will Be Paid Under the New MACRA Legislation and How To Prepare For It

Disclosures: Dr. Henry is affiliated with www.EHRGURU.net and has lectured for numerous companies including Topcon, First Insight, RevolutionEHR, FoxFire, VisionWeb, SolutionReach, and the AOA.

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Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

3 Goals for our health care system

Medicare Access & CHIP (Children’s Health Insurance Program) Reauthorization Act of 2015 (MACRA)

Where to go for Help, Handouts, and Future Updates

Medicare Payment Prior to MACRA

- Fee-for-service (FFS) payment system
  - Clinicians paid based on volume of services not value
- The Sustainable Growth Rate (SGR)
  - Established in 1997 to control the cost of Medicare payments
  - If overall physicians costs > target Medicare expenditures then Physician payments cut across the board
  - Each year congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments)
- MACRA replaces the SGR with a more predictable payment method that incentivizes value

MACRA

- MACRA = Medicare Access & CHIP (Children’s Health Insurance Program) Reauthorization Act of 2015
  — Signed into law April 26, 2015

- MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries
  1. Repeals the Sustainable Growth Rate (SGR) formula (from 1997) for determining Medicare payments for health care providers’ services
  2. Makes a new framework for rewarding health care providers for giving better care not just more care
  3. Streamlines multiple quality reporting programs into the new Merit based Incentive Payment System (MIPS)
MACRA

- Dept. of Health & Human Services issued a Notice of Proposed Rulemaking to implement key provision of MACRA on April 27, 2016
  - This is still not finalized
  - The following information is what has been proposed and may change
  - We don’t expect there to be significant changes in the final rule

- The proposed rule would implement these changes through a framework called the Quality Payment Program which includes two paths

Quality Payment Program: Two Paths

Quality Payment Program (QPP)

- MIPS - Merit-based Incentive Payment System Default for Medicare Eligible Clinicians
- APMs - Advanced Alternative Payment Models

Quality Payment Program

QPP Two Pathways: MIPS vs APMs

1. Merit-Based Incentive Payment System (MIPS)
   - Default plan for all Medicare eligible clinicians
   - Attempts to combine four programs into one structure, three existing incentive programs and one new program
   - Lower incentives, less certainty of incentive outcome
   - Moves the incentive / penalty bar each year based on national performance
   - Designed to be less attractive

2. Advanced Alternative Payment Models (APMs)
   - Optional plans
   - Carries higher risk, higher potential reward
   - Intended to be the “carrot”

- CMS anticipated initial participation:
  - MIPS: 89%
  - APMs: 11%

Pathway #1: Merit-Based Incentive Payment System (MIPS)

Path #1: Merit-based Incentive Payment System (MIPS)

- MIPS applies to individual Eligible Clinicians (ECs), groups of ECs or virtual groups
- Includes “Medicare Eligible Clinicians”
  - Year 1 & 2: Physicians, Physician assistants, Nurse practitioners, Clinical nurse specialists, Certified registered nurse anesthetists
  - Years 3+: Physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dietitians, nutritional professionals
- Will be most common for ODs
- Most Medicare ECs will initially participate in MIPS
MIPS – Excluded ECs

- There are 3 groups of physicians who will NOT be subject to MIPS:
  - ECs in their first year of Medicare participation
  - ECs significantly participating in an Advanced Alternative Payment Model (APM)
  - ECs that are low volume threshold
    - Have less than or equal to $10,000 in Medicare charges and less than or equal to 100 Medicare Patients
  - MIPS does not apply to hospitals or facilities

MIPS Composite Performance Score

- Each year ECs will get a single composite performance score from 0 – 100

- Composite score based on 4 weighted (changes by year) performance categories
  1. Quality of outcomes (formerly PQRS)
  2. Use of Health IT – (formerly Meaningful Use)
  3. Cost of outcomes (formerly VM)
  4. Better process – (new program, Clinical Practice Improvement Activities)

MIPS Payment Adjustment

- Based on a MIPS Composite Performance Score, Clinicians will receive a positive, negative, or neutral adjustment based on if their score is above, below or at the performance threshold up to the set percentages for each year
  - Threshold for success determined after the year is over
- You won’t know how you are doing until the year is over

MIPS Category Weight and Adjustment

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022 and beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality (PQRS)</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use (VM)</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities (ACI)</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information (MU)</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>MIPS Adjustment Factor (+/-)</td>
<td>4%</td>
<td>5%</td>
<td>7%</td>
<td>9%</td>
</tr>
</tbody>
</table>

* In 2019, exceptional performers will be eligible for up to 12% increase (3 x base rate)
** In 2020 to 2026, exceptional performers will be eligible for a 10% increase Up to $500M available each year from 2019 – 2024

Because MIPS adjustments are budget neutral a scaling factor may be applied to upward adjustments to make total upward and downward adjustments equal

MIPS Composite Performance Scoring Changes By Year

- Quality: Formerly PQRS (Physician Quality Reporting System)
- ACI: Advancing Care Information, formerly MU (Meaningful Use)
- CPIA: Clinical Practice Improvement Activities, New

MIPS Composite Performance Score

A single MIPS composite performance score will be calculated in 4 weighted performance categories on a 0-100 point scale

- Quality
- Resource Use
- Clinical Practice Improvement Activities
- Advancing Care Information

MIPS Composite Performance Score (CPS)
MIPS Scoring Strategy

- A single MIPS composite performance score will factor in performance in 4 weighted categories on a 0-100 point scale

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Maximum Points</th>
<th>Percentage of MIPS Score (2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>80 to 90 points depending on group size</td>
<td>50%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>Average score of all resource use measures</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities</td>
<td>60 points</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>100 Points</td>
<td>25%</td>
</tr>
</tbody>
</table>

Scoring for Performance Category: Quality

- Clinicians choose six measures (273 MIPS Quality Measures / PQRS measures included for 2017) to report to CMS that best reflect their practice
  - One measure must be an outcomes measure or high-priority measure
  - One measure must be a crosscutting measure
  - CMS calculates 2-3 population measures based on claims data
    - 2-9 clinicians = 2 population measures
    - >=10 clinicians = 3 population measures
  - Groups of 100 or more who report via GPRO must participate in CAHPS (Consumer Assessment of Healthcare Providers & Systems) survey
    - CAHPS survey is a patient satisfaction survey

Scoring Performance Category: Quality

- Individual: 273 measures – may be performed by anyone
  - 18 new
  - 70 significantly changed
  - 185 unchanged
- Cross-cutting: 10 measures – involves multiple modalities
  - 3 significantly changed
  - 7 unchanged
- Outcomes: 69 measures
  - 6 new
  - 19 significantly changed

Scoring Performance Category: Quality

- Measure Development Plan
  - Hundreds of measures in the pool
  - New versions of measures will be proposed every May
  - New versions will be finalized November 1st
  - Final versions will become effective January 1st

- Scoring of measures:
  - To be counted at least 20 cases must be in the denominator for a measure
  - Each measure scores 0-10, depending on performance against benchmark
    - Baseline / benchmark set from data 2 years prior
    - 0 points for measures not reported
  - Performance plus bonus points are added and divided by 10X the number of scored measures
  - Translates into 50% of MIPS score in 2017
**Scoring Performance Category: Quality**

- Each scored measure is converted to points 1-10
- CMS publishes deciles based on national performance in a baseline period (2 years prior to performance period)
- ECs performance is compared to published decile breaks
- Points are assigned for each measure based on which decile range your performance data is located.
  - All scored measures receive at least 1 point

![Quality Points Based on Deciles](image)

**Quality Points Based on Deciles**

<table>
<thead>
<tr>
<th>Decile</th>
<th>Possible Points</th>
<th>0%</th>
<th>7%</th>
<th>14%</th>
<th>21%</th>
<th>28%</th>
<th>35%</th>
<th>42%</th>
<th>49%</th>
<th>56%</th>
<th>63%</th>
<th>70%</th>
<th>77%</th>
<th>84%</th>
<th>91%</th>
<th>98%</th>
<th>100%</th>
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<tbody>
<tr>
<td>Decile 1</td>
<td>1.0</td>
<td>0.7</td>
<td>0.4</td>
<td>0.1</td>
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<tr>
<td>Decile 2</td>
<td>2.0</td>
<td>1.4</td>
<td>0.8</td>
<td>0.4</td>
<td>0.1</td>
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<tr>
<td>Decile 3</td>
<td>3.0</td>
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<td>Decile 4</td>
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<tr>
<td>Decile 6</td>
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<td>0.5</td>
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<tr>
<td>Decile 7</td>
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<tr>
<td>Decile 8</td>
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<td>1.5</td>
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<tr>
<td>Decile 9</td>
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<td>Decile 10</td>
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</tr>
</tbody>
</table>

**Quality Category: Bonus Points**

Bonus Points:
- Up to 10% “extra credit” total in bonus points
  - Additional high priority measures (up to 5% of possible total)
    - 2 bonus points awarded for additional outcome/patient experience
    - 1 bonus point for other high priority measures
  - CEHRT Bonus (up to 5% of possible total)
    - 1 bonus point for each measure reported using CEHRT
  - Not available for claims reporting

![Scoring: Quality Performance Category](image)

**MIPS Submission Options for Quality Category**

- Individual Reporting:
  - Qualified Clinical Data Registry: Data completeness - 90%
  - Qualified Registry: Data completeness - 90%
  - EHR Vendors: Data completeness - 90%
  - Claims: Data completeness - 80% of MIPS eligible clinician’s patients
- Group Reporting:
  - Qualified Clinical Data Registry
  - Qualified Registry
  - EHR Vendors
  - CMS Web Interface (groups 25 or more)
  - CAHPS for MIPS survey

**Performance Category: Quality Measures**

Sample proposed quality measures:
- Primary open angle glaucoma:
  - NQF 0086 / PQRS 012: Optic Nerve Evaluation
  - NQF 0163 / PQRS 141: Reduction of IOP by 50% or Documentation of a Plan of Care
- Age-Related macular degeneration:
  - NQF 0087 / PQRS 014: Detailed Macular Examination
  - NQF 0166 / PQRS 140: Counseling on Antioxidant Supplement
- Diabetic Retinopathy:
  - NQF 0083 / PQRS 018: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
  - NQF 0085 / PQRS 019: Communication with Physician Managing Ongoing Diabetes Care
- Diabetes:
  - NQF 0055 / PQRS 117: Eye Exam
  - NQF 0419 / PQRS 130: Documentation of Current Medications in the Medical Record
  - NQF 0028 / PQRS 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
PQRS vs New MIPS Quality Category

<table>
<thead>
<tr>
<th></th>
<th>PQRS</th>
<th>Proposed MIPS Quality Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scoring</strong></td>
<td>Report all required measures to avoid payment adjustment</td>
<td>Report all required measures, Credit received for those measures that meet the data completeness threshold. Eligible clinicians performance will influence their score</td>
</tr>
<tr>
<td><strong>Data Submission</strong></td>
<td>Required 9 measures across 3 National Quality Strategy domains</td>
<td>Required 6 measures, no NQS domain requirement</td>
</tr>
</tbody>
</table>

Scoring for Performance Category: Resource Use

Resource Use / Cost Category: is a measure of the cost efficiency of the services provided by the EC

- Up to 41 measures are chosen by CMS
- CMS calculates measures based on claims data
  - There are no reporting requirements for clinicians
- Translates into 10% of MIPS score in 2017
- No performance category score if a clinician is not attributed enough cases to meet minimum case volume
  - Points will be reallocated to Quality category
  - Most ODs will fall into this category

Scoring Performance Category: Resource Use

- Claims-based calculation: **no reporting necessary**
- 2 Value based payment modifier (VM) measures
  - Total spend per capita
  - Medicare spending per beneficiary (MSPB)
- 41 episode-specific measures
- Each measure worth up to 10 points
  - Based on cost efficiency
  - 20 patient sample minimum for each measure

Clinical Categories:

**Standard Set**
- Breast
- Cardiovascular (12)
- Cerebrovascular (2)
- Gastrointestinal (3)
- Genitourinary
- Infectious Disease
- Metabolic
- Neurology
- Musculoskeletal (5)
- Respiratory (6)
- Vascular

**Additional Set**
- Gastrointestinal (3)
- Infectious Disease
- Ophthalmology
- Musculoskeletal (2)
Scoring Performance Category: Resource Use

Case Reporting:
- 20 cases minimum
- Individual reporting: TIN/NPI level
- Group reporting: TIN level

Measures are equally weighted for a maximum of 10 points each.
- A measure is included in the scoring only if minimum case requirement is met, so the total possible points can vary between ECs.
- Performance points assigned for a measure based on benchmark decile range from the performance year.

\[
\text{Resource Use} = \frac{\text{score}}{\text{max score}} \times 10
\]

Scoring for Performance Category: Clinical Practice Improvement Activities (CPIA)

- New Category under MIPS
- Very similar to measures for Patient Centered Medical Homes
- Objective of CPIA is to use a patient-centered approach to program development that leads to better, smarter, and healthier care
- Begins with easier requirements; expect to see more stringent requirements in future years

Clinical Practice Improvement Activities (CPIA)
- 94 potential activities in 9 categories
- Depending on difficulty:
  - "High weight" measures are worth 20 points
    - High effort to implement, greater impact on outcomes
  - "Medium weight" measures are worth 10 points
    - Medium effort to implement, moderate impact on outcomes
- Each measure is all or nothing
  - Report by attestation
- Must achieve 60 points to get full credit
- Translates into 15% of your MIPS score

Pick 3-6 measures: 10 or 20 points each

60 points maximum
Subcategories of Clinical Practice Improvement

- Expanded Practice Access (4)
- Beneficiary Engagement (24)
- Population Management (16)
- Care Coordination (14)
- Participation in an APM, including Medical Home Model = Full Credit

Three additional subcategories are proposed in the NPRM

CPIA Special Scoring Considerations

- For non-patient facing clinicians and groups, small (15 or fewer professionals), practices located in rural areas and geographic health professional shortage areas:
  - First activity gets 50% of the 60 points
  - Second activity gets 100% of the 60 points
- For APMs reporting the CPIA category:
  - APM participation is automatically half of the highest potential score, with opportunity to select additional activities for full credit
- Certified patient-centered medical homes, comparable specialty practices, or Medical Homes receive highest potential score

Proposed Clinical Practice Improvement Activities Inventory

**Expanded Practice Access: 4 Activities**
- **High Weight – 20 Points**
  - Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care
  - 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 telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults, or teleaudiology pilots that assess ability to still deliver quality care to patients
  - 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
- **Medium Weight – 10 Points**
  - Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults, or teleaudiology pilots that assess ability to still deliver quality care to patients
  - 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

**Population Management: 16 Activities**
- **High weight – 20 Points**
  - Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations
  - Conduct periodic, structured medication reviews
  - Provide peer-led support for self-management
  - Achieve Health Equity (15)
  - Prepare for and manage emergencies (15)
  - Engage patients and improve patient engagement (15)
  - Address disproportionate adverse outcomes (15)

**Care Coordination: 14 Activities**
- **High weight – 20 Points**
  - Participation in the CMS Transforming Clinical Practice Initiative
  - Ensure that there is bilateral exchange of necessary patient information to guide patient care that could include one or more of the following:
  - Participate in a Health Information Exchange if available; and/or
  - Use structured referral notes
  - Implementation of regular care coordination training

**Beneficiary Engagement: 24 Activities**
- **High weight – 20 Points**
  - Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan
  - Use evidence-based decision aids to support decision making
- **Medium weight – 10 Points**
  - Provide peer-led support for self-management

**Patient Safety and Practice Assessment: 21 Activities**
- **High weight – 20 Points**
  - Participate in the CMS Transforming Clinical Practice Initiative
  - Conduct periodic, structured medication reviews
  - Provide peer-led support for self-management
- **Medium weight – 10 Points**
  - Use evidence-based decision aids to support decision making
- **Low weight – 5 Points**
  - Use telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults, or teleaudiology pilots that assess ability to still deliver quality care to patients
  - 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
Proposed Clinical Practice Improvement Activities Inventory

Patient Safety & Practice Assessment: 21 Activities
• High weight – 20 Points
  – 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
• Medium weight – 10 Points
  – Use decision support and protocols to manage workflow in the team to meet patient needs
  – Use of QCDR data, for ongoing practice assessment and improvements in patient safety

Proposed Clinical Practice Improvement Activities Inventory

Participation in an APM: 1 Activities
• For APMs reporting the CPIA category:
  – APM participation is automatically half of the highest potential score, with opportunity to select additional activities for full credit
• Certified patient-centered medical homes, comparable specialty practices, or Medical Homes receive highest potential score

Proposed Clinical Practice Improvement Activities Inventory

Achieving Health Equity: 5 Activities
• High weight – 20 Points
  – Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare
• Medium weight – 10 Points
  – Participation in State Innovation Model funded activities

Proposed Clinical Practice Improvement Activities Inventory

Emergency Response & Preparedness: 2 Activities
• Medium weight – 10 Points
  – Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups must be registered for a minimum of 6 months as a volunteer for domestic or international humanitarian volunteer work
  – Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of 6 months as a volunteer for disaster or emergency response

Proposed Clinical Practice Improvement Activities Inventory

Integrated Behavioral & Mental Health: 8 Activities
• High weight – 20 Points
  – Integration facilitation, and promotion of the colocation of mental health services in primary and/or non-primary clinical care settings
• Medium weight – 10 Points
  – Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence
  – Unhealthy alcohol use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including screening and brief counseling (refer to NQF #2152) for patients with co-occurring conditions of behavioral or mental health condition

CPIA Scoring

Total CPIA Points

Total Possible CPIA Points (60)

CPIA Performance Category Score
Data Submission Options for CPIA Category

- Individual Reporting:
  - Qualified Clinical Data Registry
  - Qualified Registry
  - EHR Vendors
  - Administrative claims (if technically feasible, no submission required)

- Group Reporting:
  - Attestation
  - Qualified Clinical Data Registry
  - Qualified Registry
  - EHR Vendors
  - CMS Web Interface (groups 25 or more)
  - Administrative claims (if technically feasible, no submission required)

Data Submission for CPIA

- For the first year, all MIPS eligible clinicians or groups, or third party entities, must designate a yes/no response for ALL 94 activities on the CPIA inventory

- This is auditor’s heaven: how will you document that you did what you said?
  - We are awaiting guidance from CMS

Scoring for Performance Category: Advancing Care Information

- This is the New Meaningful Use
  - Proposed to replace meaningful use in 2017
  - Necessary to comply with statutory requirement to continue mission of HITECH
  - Intent is to add flexibility and reduce reporting burden
  - Uses the same objectives with some minor changes from MU final rule in 2015
  - Scoring of objectives is entirely different from MU

Scoring Performance Category: Advancing Care Information

- **Base Score**
  - Accounts for 50 points
  - Primary option: 11 measures (many stage 3)
  - Alternate option: 16 measures (all modified stage 2)
  - Accounts for 80 points
  - Up to 1 point
  - Earn 100 points (out of 131) and receive full 25 points in the ACI category

- **Performance Score**
  - Stage 3 measures (up to 10 points each)
  - Stage 2 measures (up to 10 points each)

- **Bonus Point**
  - 1 point for doing at least one extra registry beyond immunization

- **Composite Score**
  - No threshold requirement
  - For objectives with a yes/no response must have a yes to receive credit
  - If Protect Health Information is not achieved: entire ACI score is 0

Advancing Care Information

- Base Score
  - Accounts for 50 percentage points of total score in ACI category
  - 11 (primary option) or 16 (alternate option) measures
  - All or nothing scoring on each base measure

- To receive the base score:
  - Physicians must simply provide the numerator/denominator or yes/no for each of the six required objectives made up of 11 or 16 measures
  - For objectives with a numerator/denominator must have at least a 1 for the numerator to receive credit
  - No threshold requirement
  - For objectives with a yes/no response must have a yes to receive credit
  - If Protect Health Information is not achieved: entire ACI score is 0
Scoring Performance Category: Advancing Care Information Base Score

Base Score Options for 2017 only

- **Primary Proposal**
  - Base score uses Stage 3 measures
- **Alternate Proposal**
  - Base score uses Modified Stage 2 measures

- You can choose Primary or Alternate Proposal based on what certification edition of software you have in place
  - Use 2015 edition:
    - Primary or alternate proposal
  - Use 2014 edition:
    - Alternate proposal
      - This would mean using 2014 edition entire calendar year (very unlikely and not recommended since Jan 1, 2018 you will be required to use 2015 edition)
  - Use Combination 2014 and 2015 edition:
    - Primary proposal or alternate proposal

---

### Scoring Performance Category: Advancing Care Information Base Score

**Base Score: Primary Proposal 11 Measures**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Stage 2</th>
<th>Stage 3</th>
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<tr>
<td>1</td>
<td>Protect Patient Health Information</td>
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<tr>
<td>2</td>
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<td>3</td>
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<td>Computerized Provider Order Entry (CPOE)</td>
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<tr>
<td>5</td>
<td>Laboratory Orders</td>
<td>6</td>
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<tr>
<td>6</td>
<td>Imaging Orders</td>
<td>7</td>
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<td>7</td>
<td>Patient Access</td>
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<td>Patient-Specific Education</td>
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<td>9</td>
<td>Secure Messaging</td>
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<td>Health Information Exchange</td>
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<td>11</td>
<td>Medication Reconciliation</td>
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<tr>
<td>12</td>
<td>Immunization Registry Reporting</td>
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<tr>
<td>13</td>
<td>Syndromic Surveillance Reporting</td>
<td>15</td>
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</tr>
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### Scoring Performance Category: Advancing Care Information Base Score

**Base Score: Alternate Proposal 16 Measures**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
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<th>Stage 3</th>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Electronic Prescribing</td>
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</tr>
<tr>
<td>3</td>
<td>Clinical Decision Support (CDS)</td>
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<tr>
<td>4</td>
<td>Computerized Provider Order Entry (CPOE)</td>
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<tr>
<td>5</td>
<td>Laboratory Orders</td>
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<td>Imaging Orders</td>
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<td>Medication Reconciliation</td>
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<td>Immunization Registry Reporting</td>
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<tr>
<td>13</td>
<td>Syndromic Surveillance Reporting</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

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### Advancing Care Information: Base Score

CMS proposes six objectives and their measures that would require reporting for the base score:

- Protect Patient Health Information
  - (you required)
- Electronic Prescribing
  - (required/optional)
- Patient Electronic Access
  - (required/optional)
- Coordination of Care Through Patient Engagement
  - (required)
- Health Information Exchange
  - (required/optional)
- Public Health and Clinical Data Registry Reporting
  - (required/optional)

---

### Protect Electronic Health Information

- Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician’s risk management process
- If you don’t complete this objective you will receive a **zero score for the entire Advancing Care Information category of MIPS**
Protect electronic health information

- A major goal of the Security Rule is to protect the privacy of individuals’ health information while allowing covered entities to adopt new technologies to improve the quality and efficiency of patient care.
  - This is similar to the current HIPAA security rules.
- You must document and conduct or review a security risk analysis and implement updates as necessary.
  - Should be done once prior to end of reporting period.
- Your software vendor should be able to provide you with tools to complete the risk analysis.

Protect electronic health information

- HIPAA protects the privacy of individually identifiable health information, called protected health information (PHI).
- Security Rule protects a subset of information covered by the Privacy Rule, which is all individually identifiable health information a covered entity creates, receives, maintains or transmits in electronic form. The Security Rule calls this information “electronic protected health information” (e-PHI).

Annual Security Risk Assessment Cycle

1. Conduct a security risk assessment.
2. Identify risks, threats, and vulnerabilities.
3. Mitigate risk, threats, and vulnerabilities.
4. Develop remediation plan.
5. Monitor results.

Where to get more help:

http://www.healthit.gov/providers-professionals/security-risk-assessment

Electronic Prescribing

- At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology.
  - May report a null value if write fewer than 100 permissible prescriptions for the performance period.
E-Prescribing (eRx)

Clinical Significance?

- Improves medication safety
- Better management of medication costs
- Improved prescribing accuracy and efficiency
- Increase practice efficiency
- Reducing health care costs
- Reduction of adverse drug events

Patient Electronic Access

- **Measure 1: Patient Access:** For at least one unique patient seen by the MIPS eligible clinician:
  - (1) The patient (or the patient authorized representative) is provided timely access to view online, download, and transmit his or her health information; and
  - (2) The MIPS eligible clinician ensures the patient’s health information is available for the patient (or patient—authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician’s certified EHR technology

- **Measure 2: Patient Education:** The MIPS eligible clinician must use clinically relevant information from certified EHR technology to identify patient-specific educational resources and provide electronic access to those materials to at least one unique patient seen by the MIPS eligible clinician
**Patient Electronic Copy and Electronic Access: API**

- Application Programming Interface (API)
- API is a set of programming protocols
- Enables access to data via third-party applications
- More flexible than a patient portal
- If API provides view, download, transmit than a patient portal is not needed separately

---

**Patient Education**

**Clinical Significance?**

- It is our job as a doctor to properly educate our patients on all of their clinical findings and diagnosis as well as risks and benefits of each treatment option
- Certified EHRs have the ability to identify patient specific educational resources based on the problem list, medication list, or lab test results
- The EHR technology must identify the patient educational material or resources
  - The resources do not have to be stored within or generated by the EHR

---

**Coordination of Care Through Patient Engagement**

- **Measure 1: View Download and Transmit:** During the performance period, at least one unique patient (or patient-authorized representative) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS eligible clinician and either:
  - (1) view, download or transmit to a third party their health information
  - (2) Access their health information through the use of an API
  - (3) Uses a combination of (1) and (2) above
- **Measure 2: Secure Messaging:** For at least one unique patient seen by the MIPS eligible clinician during the performance period, a secure message was sent using the electronic messaging function of certified EHR technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative)
- **Measure 3: Patient-Generated Health Data:** Patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for at least one unique patient seen by the MIPS eligible clinician during the performance period
Secure Messaging

Information From Patient or Non-Clinical Setting

- Information from patient
  - Patient generates the data on their own
  - Recording own vital signs, activity and exercise, medication intake, nutrition

- Information from non-clinical setting

- Non-EP or non-hospital provider who doesn’t have access to the EPs EHR
  - Nutritionists, physical therapists, occupational therapists, psychologists, home health providers

- Could include:
  - Social service data, advanced directives, medical device data, fitness monitoring, etc.

Health Information Exchange

- Measure 1: Patient Care Record Exchange: For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider
  - (1) creates a summary of care record using certified EHR technology and
  - (2) electronically exchanges the summary of care record

- Measure 2: Request / Accept Patient Care Record: For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician receives or retrieves and incorporates into the patient’s record an electronic summary of care document

- Measure 3: Clinical Information Reconciliation: For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician performs clinical information reconciliation:
  - The clinician must implement clinical information reconciliation for the following three clinical information sets:
    - (1) Medication: Review of the patient’s medication, including the name, dosage, frequency, and route of each medication
    - (2) Medication allergy: Review of the patient’s known medication allergies
    - (3) Current Problem List: Review of the patient’s current and active diagnoses
Summary of Care Record for Transitions of Care

Clinical Significance?

• You must provide a summary of care record to the provider you are referring the patient to
  – This is important because it allows the next provider of care to understand your clinical findings which may impact the patients care
  – You could use the clinical summary or your electronic copy

• You must have 10% of the summaries transmitted electronically
  – This is why secure (direct) messaging is so important!
  – Eventually you will be able to look up a doctors direct email address on the NPPES website

Clinical Information Reconciliation
Public Health and Clinical Data Registry Reporting

- **Immunization Registry Reporting:**
  - The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).
  - Report as a Yes/No
    - If you do not provide immunizations you may report a null

- **Optional Reporting**
  - Syndromic Surveillance
  - Electronic Case
  - Public Health Registry
  - Clinical Data Registry

Public Health Reporting

- **Active Engagement** is defined as:
  - **Option 1:** Completed registration to submit data: Registration was completed within 60 days after the start of the EHR reporting period and the EP is awaiting an invitation from the PHA or CDR to begin testing
  - **Option 2:** Testing and Validation: EP is in the process of testing and validation of the electronic submission of data. EPs must respond to requests from the PHA within 30 days; failure to respond twice within a reporting period would result in failure to meet this objective
  - **Option 3:** Production: EP has completed testing and validation and is electronically submitting production data to PHA or CDR

Public Health Reporting: Immunization Registry

- EP is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories

- You may excluded from this measure:
  - If you do not administer any immunizations to any of the populations for which data is collected
  - Operate in a jurisdiction for which no immunization registry is capable of accepting the specific standards required
  - Operate in a jurisdiction where no immunization registry has declared readiness to receive data at the start of the reporting period

Public Health Reporting

- To meet this objective you must be in **active engagement** with a Public Health Agency or clinical data registry to submit electronic data in a meaningful way using CEHRT, except where prohibited and in accordance with applicable law and practice
Advancing Care Information: Base Score Alternate Proposal

Electronic Prescribing

- At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology
  - May report a null value if write fewer than 100 permissible prescriptions for the performance period

Clinical Decision Support

- **Measure 1: Interventions Measure:** Implement three clinical decision support interventions related to three CQMs at a relevant point in patient care for the entire performance period
- **Measure 2: Drug Interaction and Drugs-Allergy Checks:** The MIPS eligible clinician has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire performance period

Clinical Decision Support Details

- **Clinical Decision Support:**
  - Functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care

Protect Electronic Health Information

- Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician’s risk management process.
  - If you don’t complete this objective you will receive a zero score for the entire Advancing Care Information category of MIPS

Implement clinical decision support

- **Clinical Significance?**
  - These are rules designed to help us meet the standard of care in terms of testing and follow up care
  - **Examples:**
    - If a patient has an active medication of Plaquenil listed, has a macular visual field, color vision testing, and a SD OCT been ordered?
    - When an IOP is above a specific level, a warning of possible glaucoma is triggered
    - If a diagnosis of glaucoma is entered, is the patient scheduled or have they had a VF or a scanning laser within the last 6 - 12 months
This combination may increase statin levels, risk of myopathy, kidney and/or liver damage may result.

**Computerized Provider Order Entry**

- **Measure 1: Medication Orders**: At least one medication order created by the MIPS eligible clinician during the performance period is recorded using CPOE.

- **Measure 2: Laboratory Orders**: At least one laboratory order created by the MIPS eligible clinician during the performance period is recorded using CPOE.

- **Measure 3: Diagnostic Imaging Orders**: At least one diagnostic imaging order created by the MIPS eligible clinician during the performance period is recorded using CPOE.

**CPOE Details**

- **Computerized Provider Order Entry (CPOE)**: A provider’s use of computer assistance to directly enter medical orders from a computer or mobile device.
  - **Laboratory Order**: Order for any service provided by a laboratory that could not be provided by a non-laboratory.
  - **Diagnostic Imaging Order**: Order for any imaging services that uses ultrasound, magnetic resonance, computed tomography, radiologic, and other imaging.

**Computerized Provider Order Entry**

**Clinical Significance?**

- Directly entering orders into a computer has the benefit of reducing errors by minimizing the ambiguity of hand-written orders, but a much greater benefit is seen with the combination of CPOE and clinical decision support tools.
- Implementation of CPOE is being increasingly encouraged as an important solution to the challenge of reducing medical errors, and improving health care quality and efficiency.
• Measure 1: Patient Access: At least one patient seen by the MIPS eligible clinician during the performance period is provided timely access to view online, download, and transmit to a third party their health information subject to the MIPS eligible clinician’s discretion to withhold certain information

• Measure 2: View, Download, Transmit: At least one patient seen by the MIPS eligible clinician during the performance period (or patient-authorized representative) views, downloads or transmits their health information to a third party during the performance period

• The MIPS eligible clinician must use clinically relevant information from certified EHR technology to identify patient-specific educational resources and provide access to those materials to at least one unique patient seen by the MIPS eligible clinician

• For at least one patient seen by the MIPS eligible clinician during the performance period, a secure message was sent using the electronic messaging function of certified EHR technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient authorized representative) during the performance period
Health Information Exchange

- The MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider:
  - (1) uses certified EHR technology to create a summary of care record; and
  - (2) electronically transmits such summary to a receiving health care provider for at least one transition of care or referral

Medication Reconciliation

Clinical Significance?
- This is very important to our patient care
- Unintended inconsistencies in medication regimens may occur at any point of transition in care
- The goal is to review all medications a patient is taking with them and provide them with a current updated list after each encounter
  - This helps avoid negative drug interactions as well as drug duplication
- Medication reconciliation is the process of identifying the most accurate list of all medications the patient is taking by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider
Public Health Reporting

- **Measure 1: Immunization Registry**: The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data.
- **Measure 2: Syndromic Surveillance Registry**: The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data.
- **Measure 3: Specialized Registry Reporting**: The MIPS eligible clinician is in active engagement to submit data to a specialized registry.

Advancing Care Information: Performance Score

- **Performance score**
  - Accounts for up to 80 percentage points
  - Eight measures below accounting for 10 possible points each
  - Each measure is scored
  - Score = \( \frac{\text{numerator}}{\text{denominator}} \times 10 \)
- Physicians select the measures that best fit their practices from the following:
  1. Patient electronic access
  2. Patient specific education (modified Stage 2)
  3. Coordination of care through patient engagement
  4. Secure messaging (modified Stage 2)
  5. Patient generated health data (Stage 3)
  6. Health information exchange
  7. Patient care record exchange (modified Stage 2)
  8. Clinical information reconciliation (Stage 3)

Performance scoring examples:

- No thresholds
  - You get credit for how often you complete each measure
  - Scoring based on key measures of patient engagement and information exchange
  - Flexible scoring for all measures to promote care coordination of better outcomes

- Percentage of time you do the measure determines score (numerator / denominator) \times 10
  - Example: patient education is 100% for your 4000 patients
    - Score = \( \frac{4000}{4000} \times 10 = 10 \) points
  - Example: View, download, transmit (VDT) is low, 5% of your 4000 patients
    - Score = \( \frac{200}{4000} \times 10 = .5 \) points

Advancing Care Information: Bonus Point

**Registry Bonus Point**:

- 1 extra point towards your score for participation in one or more extra registry beyond immunization registry
- Maximum score is 1 point
  - Even if you participate in multiple extra registries
- Potential registries:
  - Syndromic Surveillance
  - Electronic Case Reporting
  - Public Health Registry Reporting
  - Clinical Data Registry Reporting
Performance score based on sum of % you complete each measure

<table>
<thead>
<tr>
<th>Measure</th>
<th>Patient Access</th>
<th>Coordination of Care Through Patient Engagement</th>
<th>Health Information Exchange (HIE)</th>
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<tbody>
<tr>
<td>Patient Access</td>
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</tr>
<tr>
<td>Patient-Specific Education</td>
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<td></td>
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<td>VOT</td>
<td>6.0%</td>
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</tr>
<tr>
<td>Secure Messaging</td>
<td>5.0%</td>
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<tr>
<td>Patient-Generated Health Data</td>
<td>5.0%</td>
<td></td>
<td></td>
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<tr>
<td>Patient Care Record</td>
<td>5.0%</td>
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</tr>
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<td>Report of Patient Care Record</td>
<td>4.8%</td>
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<tr>
<td>Clinical Information</td>
<td>5.5%</td>
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</tr>
</tbody>
</table>

Base Score

Performance Score = 87.5 ACI points * 0.25 = 21.88 (out of 25) MIPS points for the ACI category

MIPS Submission Options for Advancing Care Information

- Individual Reporting
  - Attestation
  - Qualified Clinical Data Registry
  - Qualified Registry
  - EHR

- Group Reporting
  - Attestation
  - Qualified Clinical Data Registry
  - Qualified Registry
  - EHR
  - CMS Web Interface (groups of 25 or more)

Changes from Current Meaningful Use Program to New Advancing Care Information

- Key Changes from current Meaningful Use Program
  - Dropped “all or nothing” threshold for measures
  - Removed redundant measures to make reporting easier
  - Eliminated computer provider order entry and clinical decision support objectives
  - Reduced the number of or public health registries to which clinicians must report

Composite Performance Score Calculations
**Composite Performance Score**

**Different Ways to Obtain Same Score**

Eligible Clinician Has Average or Above Average Score in All Categories

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Score</th>
<th>Weight</th>
<th>Weighted Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>0%</td>
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<td>5%</td>
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<tr>
<td>Resources Use</td>
<td>0%</td>
<td>6%</td>
<td>5%</td>
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<tr>
<td>Clinical Process</td>
<td>0%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Advancing Care Info</td>
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<td>6%</td>
<td>5%</td>
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<tr>
<td>Composite Performance Score (Minimum 80)</td>
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<td>6%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Eligible Clinician Excels in Quality; Does Not Earn Advancing Care Information

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Score</th>
<th>Weight</th>
<th>Weighted Score</th>
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<tbody>
<tr>
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<td>6%</td>
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<tr>
<td>Composite Performance Score (Minimum 100)</td>
<td>80%</td>
<td>6%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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**MIPS Payment Adjustments**

- Payment adjustment is at the TIN / NPI level
- Exclude TIN/NPIs that meet exclusion criteria
  - Newly enrolled, Qualifying APM participant, Partial qualifying APM, low volume threshold
- If clinician changed groups after performance period
  - Performance follows NIP
- If NPI worked for more than 1 TIN, take the average of the TIN/NPI scores

---

**MIPS Opportunities for Incentives**

- Once performance threshold is determined, ALL eligible clinicians above the threshold will be eligible to receive positive payment adjustment
  - There is no requirement that a certain number of clinicians receive negative adjustments
- To get incentives, you must submit data
  - If you do not submit data, the law requires you to get a zero performance and a negative adjustment

---

**Excluded from MIPS**

- Projected for 2019 (based on 2017 performance) some clinicians will be ineligible for MIPS for reasons such as low volume or newly enrolled clinician
  - Total Clinicians projected: 540,058
  - Optometrists projected: 17,420

---

**MIPS Projected Payment Adjustments**

- Based on 2014 available data Optometry would have:
  - 18,294 providers eligible for MIPS
    - 79.7% would receive a negative payment adjustment
    - 20.2% would receive a positive payment adjustment

---

**Pathway #2: Advanced Alternate Payment Models**
Pathway #2: Advanced Alternate Payment Models (APMs)

- APMs are new approaches to paying for medical care through Medicare that incentivize quality and value
- Each model is unique but they all have shared characteristics:
  - Some financial benefit for achieving quality
  - Adds 5% bonus to Medicare payments over and above the APM's model itself
  - Utilize certified EHR technology
  - More than “nominal” financial risk
  - Use quality measure “similar” to MIPS
  - Generally requires sharing of information across care locations
- Proposed types of Advanced APMs include:
  - Comprehensive ESRD Care Model (Large Dialysis Organization)
  - Comprehensive Primary Care Plus (CPC+) – can add about 5000 practices
  - Next Generation ACO Model
  - Oncology Care Model Two-Sided Risk Arrangement (2018)
  - Medicare shared savings programs – Track 2 and Track 3

Advanced Alternate Payment Models (APMs)

- Becoming a Qualified Participant of an Advanced APM (QP)
- Being in an Advanced APM isn’t enough
  - You must achieve specific volume levels to qualify for incentives
  - May form group to reach volume
  - 2019-2020 Medicare payments and patients only
  - 2021 and forward, may include non-Medicare

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>2019</th>
<th>2020</th>
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<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>75%</td>
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<tr>
<td>%Patients</td>
<td>20%</td>
<td>20%</td>
<td>35%</td>
<td>35%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Financial Impact of Advanced APM Participation

- Continue to get current incentives tied to Advanced APM
  - 2019 – 2024:
    - MIPS participation waived
    - 5% Medicare Part B incentive
  - 2026 and forward:
    - MIPS participation waived
    - Higher fee schedule update in place of 5% incentive

Advanced APMs Participation

- All clinicians will report via MIPS in 2019 payment year (2017 participation year)
- Membership in APMs will be validated 6 months after the performance year closes
- If clinicians participate to some extent in APMs but don’t meet the criteria for sufficient participation they will receive favorable credit in the MIPS clinical practice improvement activities category
- The proposed rule makes it easy for clinicians to move between MIPS or APMs
- It is advised that everyone report on MIPS until you are certain you are qualified in a stable advanced APM

Potential Value-Based Rewards

- You can do any of the following:
  - MIPS participation only
    - You will get MIPS adjustments (discussed earlier)
  - Partial APM participation
    - You will get APM specific rewards plus MIPS adjustments
  - Advanced Eligible APM participation
    - You will receive eligible APM specific rewards plus 5% lump sum bonus
Payment Adjustments

• The separate payment adjustments under PQRS, VM and EHR-MU will end on Dec 31, 2018
  – These are based on your 2016 performance
  – They will be factors in MIPS so you still need to understand the above programs

• January 1, 2019 the Merit-Based Incentive Payment System (MIPS) and Advanced Alternate Payment Model (APM) incentive payments begin
  – These are based on your 2017 performance

How will MACRA affect me?

Timeline

2016 Performance / 2018 Payment Adjustments

2018 Payment Adjustments

• PQRS
  – 2% penalty based on participation in 2016
• Medicare EHR Incentive Program
  – 3% penalty based on participation in 2016
• Value Based Payment Modifier (VM)
  – Mandatory quality-tiering for PQRS reporters
    • Groups 2-9 EPs and solo physicians will see +/-2% adjustment based on quality-tiering
    • Groups with 10+ EPs will see +/-4% adjustment
  – Non-PQRS reporters will see automatic 2% penalty unless in group of 10+ and they will see 4% penalty

Quality & Resource Use Reports
QRUR Report – GET THEM!

• Quality and Resource Use Report (QRUR)

• Download your 2015 mid-year report now to understand your TIN’s current quality and cost performance

• Review quality measures benchmarks under the VM

How to Obtain a QRUR

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QUR.html

Questions?

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