MIPS: The Final Rule and You

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What are the current expectations?

- Three distinct programs must be satisfied and each has its own penalty:
  - Medicare EHR Incentive Program (MU)
  - Physician Quality Reporting System (PQRS)
  - Value-Based Payment Modifier (VBM)

- Depending on size of the practice, lack of satisfying all of the above would result in a **7-10% penalty** for Medicare Part B services in 2018
MACRA

- Medicare Access and CHIP Reauthorization Act of 2015
  - Repeals the Sustainable Growth Rate formula
  - Changes the way that Medicare rewards providers for value over volume
  - Streamlines multiple quality reporting programs under the Quality Payment Program (QPP)

\[
UAF_{2015} = \frac{\text{Target}_{2014} - \text{Actual}_{2014}}{\text{Actual}_{2014}} \times 0.75 + \frac{\text{Target}_{4/96-12/14} - \text{Actual}_{4/96-12/14}}{\text{Actual}_{2014}} \times (1 + SGR_{2015}) \times 0.33
\]
MACRA

Quality Payment Program

APMs

MIPS

0.1% of eligible ODs in 2017
10% of clinicians in 2017
90% of clinicians in 2017
99.9% of eligible ODs in 2017
The Merit-based Incentive Payment System (MIPS)

• Starts in 2019 based on 2017 performance

• Eliminates the separate penalties of each quality reporting program and, instead, assigns the provider a final score of 0-100 based on performance in four key areas:

  - Advancing Care Information (MU)
  - Quality (PQRS)
  - Improvement Activities

2019
The Merit-based Incentive Payment System (MIPS)

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  - Quality (PQRS)
  - Cost (Value-based Payment Modifier)
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  - Quality (PQRS)
  - Cost (Value-based Payment Modifier)
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2021+
The Merit-based Incentive Payment System (MIPS)

• Final scores of all providers calculated and compared

• Mean or Median (decision of which still not official) becomes the “performance threshold”
  • Providers with final scores below threshold will experience downward adjustment of their Medicare Part B Fee Schedule
  • Providers with final scores above threshold will experience upward adjustment of their Medicare Part B Fee Schedule

• Size of payment adjustment depends on how far away from threshold the provider’s final score is
  • the farther above threshold score, the greater the upward adjustment
  • the farther below threshold score, the greater the downward adjustment
  • potential for +/- 9% by 2022
The Merit-based Incentive Payment System (MIPS)

Maximum Adjustments:

-4% -5% -7% -9%

Adjustment to provider’s base rate of Medicare Part B payment

2019 2020 2021 2022 onward

Merit-Based Incentive Payment System (MIPS)
The Merit-based Incentive Payment System (MIPS)

• Who is excluded?
  1. Newly-eligible Medicare clinicians
  2. APM qualifiers or partial qualifiers that opt out
  3. Those below a low volume threshold
     • proposal: below $10,000 and 100 patients
     • final: below $30,000 or 100 patients
        • will exclude 32.5% more than proposal
The Merit-based Incentive Payment System (MIPS)

- Who is excluded?
  3. **Those below a low volume threshold**
    - determined via a 24 month, dual period review
      - 1st is Sept 1 - Aug 31 of year prior to performance
      - 2nd is Sept 1 - Aug 31 of performance year
    - under threshold for either period results in exclusion
The Merit-based Incentive Payment System (MIPS)

- Who is excluded?
  3. **Those below a low volume threshold**
    - Determined at clinician *or* group level depending on participation plans
      - 3 clinician practice
        - Doc A: $20,000 and 50 patients
        - Doc B: $20,000 and 50 patients
        - Doc C: $20,000 and 50 patients

Individuals
($20,000 and 50 patients)

Group
($60,000 and 150 patients)

Under threshold

Exceeds threshold
The Merit-based Incentive Payment System (MIPS)

• How did ODs fare in the exclusion analysis?
  • based on 2015 data
    • 66.7% of ODs would be excluded
      • 59.6% due to being under low volume threshold
      • 6.9% due to being newly eligible Medicare
      • 0.1% due to being in advanced APM
The Merit-based Incentive Payment System (MIPS)

- How will you participate in MIPS?
  - **Eligible Clinician**
    - each NPI/Tax ID combination is a different clinician
  - **Group**
    - defined as 2 or more clinicians that have billing rights assigned to the TIN
    - performance assessed at group level rather than individual
      - must add all clinician data together
    - no registration required, but voluntary process proposed to aid in assistance
      - voluntary registration would not restrict group to that method of reporting
The Merit-based Incentive Payment System (MIPS)

• How will you submit your MIPS data?
  • Participation options (eligible clinician, group) have their own submission mechanism options for each performance category

• **Can:**
  • report via different mechanisms for each category
    • ie. attestation for Advancing Care Info, claims-based for Quality

• **Cannot:**
  • report via different mechanisms within a category
    • ie. Registry and claims-based for Quality
  • report as a group for one category and an individual for another
    • If elect to report as a group, must report as a group for all performance categories
The Merit-based Incentive Payment System (MIPS)

• When will you report for MIPS?
  • deadline for most submission methods for 2017 performance year is March 31, 2018
    • exception: claims-based reporting for Quality requires that claims are processed within 60 days after the end of the performance period
The Merit-based Incentive Payment System (MIPS)

• “Pick Your Pace” in 2017
  • **Option 1**: Test the Quality Payment Program
    • submit anything
  • **Option 2**: Participate for part of the year
    • at least 90 days
  • **Option 3**: Participate for the full year

• The only way you’ll receive a negative adjustment in 2019 is if you do absolutely nothing in 2017 (submit no data)
Advancing Care Information

- 25%
- 15%
- 60%
• How is ACI different from Meaningful Use?
  • fancy new name!
  • new scoring system
    • no thresholds to meet beyond a base level of participation

**Advancing Care Information**

- **Base Score**: Up to 50 points of the total Advancing Care Information category score
- **Performance Score**: Up to 90 points of the total Advancing Care Information category score
- **Bonus Points**: Up to 15 points of the total Advancing Care Information category score

**ACI Composite Score**: Earn ≥100 points and receive 25 points in the Advancing Care Information category of MIPS
• What about the objectives?
  • **2017**: clinicians have option of modified Stage 2 objectives or Stage 3 objectives
    • Clinical Decision Support and CPOE gone
    • Stage 3 requires 2015 certified EHR technology
  
  • **2018 and beyond**: Stage 3 objectives
Advancing Care Information

• **Base score**
  - clinicians must report data for each objective
  - a numerator $\geq 1$ for %-based measures
  - a “Yes” for Protect Patient Health Information
  - report data for each objective = **50 points**
  - don’t report data for each objective = **0 points**
Performance score

- built based on actual score across measures
  - measure values range from 10 to 20 points
    - example: 80% for Patient Education = 8 of 10 points
  - no more targets/thresholds to meet (beyond 1 in the numerator needed to achieve “base” score)
What about Bonus Points?

- Syndromic Surveillance & Specialized Registries optional
  - "Active engagement" with ≥1 registry beyond Immunizations would result in 5 bonus points
  - AOA MORE

- Use of certified EHR to participate in Improvement Activities
  - Results in 10 bonus points
• Composite score
  • Base score + Performance score + Bonus Points
    • if score $\geq 100$, you receive the full 25 points
      • ability to score $>100$ gives you flexibility
    • if score is $<100$, you receive a corresponding % of 25 points
      • i.e., Base score of 50 + Performance score of 30 = 80. 80% of 25 points = 20 total points for Advancing Care Information
## Advancing Care Information

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Required?</th>
<th>Max Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
<td>Yes</td>
<td>n/a</td>
</tr>
<tr>
<td>E-Prescribing</td>
<td>E-Prescribing</td>
<td>Yes</td>
<td>n/a</td>
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<td>Patient Electronic Access</td>
<td>Provide Patient Access</td>
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<td>View, Download, or Transmit</td>
<td>No</td>
<td>10</td>
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<tr>
<td>Patient-Specific Education</td>
<td>Patient-Specific Education</td>
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<td>Secure Messaging</td>
<td>Secure Messaging</td>
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<tr>
<td>Health Information Exchange</td>
<td>Health Information Exchange</td>
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<tr>
<td>Medication Reconciliation</td>
<td>Medication Reconciliation</td>
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<tr>
<td>Public Health Reporting</td>
<td>Immunizations</td>
<td>No</td>
<td>10</td>
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<tr>
<td></td>
<td>Syndromic Surveillance</td>
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<tr>
<td></td>
<td>Specialized Registry</td>
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<tr>
<td></td>
<td>BONUS for CEHRT-related Improvement Activity</td>
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</table>

| Max Points | 105 |

* If each required measure is “Yes” or ≥1, clinician receives 50 base points
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<td>Provide Patient Access</td>
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<td>20</td>
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<td>View, Download, or Transmit</td>
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* Sum of performance in each scored measure = Performance Score

Max Points: 105
## Advancing Care Information

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<td>E-Prescribing</td>
<td>E-Prescribing</td>
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<td>Public Health Reporting</td>
<td>Immunizations</td>
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<td>0</td>
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**Performance Points**: 33

Base score of 50 + Performance score of 33 = 83. 83% of 25 points = 21 points for ACI
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<td></td>
</tr>
</tbody>
</table>

**Performance Points**

0

**Base score of 0 = 0 points for Advancing Care Information**
• What’s New?
  • Clinicians will report on **6** measures (instead of 9 like PQRS)
    1. 1 outcome measure
      1. if no outcome measures available to you, report a different high-priority measure
  • Same reporting frequency requirements
    1. Clinicians expected to report a given measure on **at least 50%** of applicable cases
  • Scored on 6 or 7 measures
    1. Individuals and small groups (≤15 providers) would have 6
    2. Larger groups (16+) would have 7
      1. active reporting by group for this measure not required. Determined via claims data
Quality

• Which measures do you report?
  • full list of measures for a performance period will be available no later than November 1 of preceding year
    • approximately 300 available for 2017
    • listed in final rule and on https://qpp.cms.gov
  • 6 measures required
    • if 6 not applicable, report on those that are
      • if <6 submitted, CMS will analyze to make sure there weren’t more you could have reported on
      • if analysis shows that there were other measures you could have reported on, you’ll receive a 0 for those and have it factored into your score
Which measures do you report?

- Ophthalmology Measure Set can provide guidance
  - 21 eye care-specific measures
  - eye care providers not required to report measures from this set, but it provides CMS’ view of applicable measures
    - i.e.: if an OD reports only 3 measures, the availability of the ophthalmology measure set makes it likely that you’d be scored 0 for those you didn’t
  - good place to start when selecting measures to report
• Which measures do you report?
  • Ophthalmology Measure Set

<table>
<thead>
<tr>
<th>Measure</th>
<th>Claims-based reporting?</th>
<th>EHR Direct?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes: Eye Exam</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Closing the Referral Loop</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Documentation of Current Medications</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>POAG: Optic Nerve Evaluation</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>POAG: IOP Reduction ≤15%</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>AMD Dilated Macular Exam</td>
<td>Yes</td>
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<tr>
<td>AMD Antioxidant Counseling</td>
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<tr>
<td>Diabetic Ret: Macular Edema</td>
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<tr>
<td>Diabetic Ret: PCP Communication</td>
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<td>Tobacco Use: Screening and Cessation</td>
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<tr>
<td>Screening for High Blood Pressure</td>
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</table>

Total available 9 8
• Scoring
  • each measure scored on scale of 0-10 points based on your performance compared to a benchmark
    • benchmark is all-provider performance on measure 2 years earlier
  • 2017 “transition year” offers a 3 point base score for each submitted measure
    • as long as you submit a measure, you can’t score below 3 points
    • you’d also receive 3 points for any submitted measure that:
      • lacks benchmark data
      • doesn’t satisfy 50% reporting frequency requirement
      • has less than 20 cases in denominator
  • 0 for any applicable measure not reported
  • Bonus points for reporting additional high-priority measures (1 or 2 points depending on type) and measures submitted via certified EHR technology (1 point each)
    • high-priority bonus requires successful performance and reporting on measure with benchmark data
### Quality

- **Claims-based reporting example #1**

<table>
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<tr>
<th>Measure</th>
<th>Measure Type</th>
<th>Performance Points</th>
<th>High-Priority Bonus</th>
<th>CEHRT Bonus</th>
</tr>
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<tbody>
<tr>
<td>Measure 1</td>
<td>Outcome</td>
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<td>0 (required)</td>
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<tr>
<td>Measure 2</td>
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<td>Measure 3</td>
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<td>Measure 6</td>
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<td><strong>Bonus Cap (10% of total possible points)</strong></td>
<td></td>
<td></td>
<td><strong>6</strong></td>
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</table>

**Total with Bonus** *30 points*

This provider would receive 30 of the 60 total possible points in Quality category
### Claims-based reporting example #2

<table>
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<th>Measure</th>
<th>Measure Type</th>
<th>Performance Points</th>
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<th>CEHRT Bonus</th>
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</thead>
<tbody>
<tr>
<td>Measure 1</td>
<td>Outcome</td>
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<td>0 (required)</td>
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<tr>
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</table>

**Total with Bonus**: 34 points

This provider would receive 34 of the 60 total possible points in Quality category.
### EHR Direct reporting example

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<td><strong>4</strong></td>
<td><strong>6</strong></td>
</tr>
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</table>

| Bonus Cap (10% of total possible points) | 6 | 6 |

**Total with Bonus**  
40 points

This provider would receive 40 of the 60 total possible points in Quality category.
Improvement Activities

- 15%  
- 25%  
- 60%
Improvement Activities

• Defined as an activity that is “likely to result in improved outcomes”
• More than 90 activities defined in the final rule
• Each activity is weighted:
  • “High” activity is worth 20 points
  • “Medium” activity is worth 10 points
  • 40 points needed for maximum performance
    • i.e., a clinician could achieve maximum performance via:
      • 2 “high” activities
      • 1 “high” and 2 “medium” activities
      • 4 “medium” activities
• Small practices (≤15 providers) only need 1 “high” or 2 “medium” activities for full credit
Improvement Activities

• **Examples of Activities**
  
  • **Expanded Practice Access**
    
    • Expanded office hours in evenings and weekends with access to the patient medical record and/or provision of same/next day care for urgent care cases (HIGH)

  • **Population Management**
    
    • Use of a qualified clinical data registry (i.e. AOA MORE) to generate regular feedback reports that summarize treatment outcomes (HIGH)

  • **Beneficiary Engagement**
    
    • Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms (MEDIUM)

  • **Emergency Response and Preparedness**
    
    • participation in domestic or international humanitarian or volunteer work for at least 60 consecutive days (HIGH)
Improvement Activities

• Using CEHRT for Improvement Activities
  • 10 point bonus within the Advancing Care Information category if clinician uses functions of certified EHR technology to accomplish an Improvement Activity
  • i.e. “If secure messaging functionality is used to provide 24/7 access for advice about urgent and emergent care (for example, sending or responding to secure messages outside business hours), this would meet the requirement of using CEHRT to complete the improvement activity and would qualify for the advancing care information bonus score”
The Merit-based Incentive Payment System (MIPS)

- ACI: 22 points
- Quality: 40 points
- Improvement Activities: 15 points

MIPS Final Score: 77 points

- Advancing Care Information (MU)
- Quality (PQRS)
- Improvement Activities
The Merit-based Incentive Payment System (MIPS)

• Example
  • Dr. Smith’s Final Score: 77
  • MIPS performance threshold: 50
  • Additional performance threshold: 70
    • $500 million in bonuses available for exceptional performance between 2019 and 2024
The Merit-based Incentive Payment System (MIPS)

- Transition year (2017)
  - **Performance threshold:** 3
    - achievable via reporting 1 Quality measure 1 time
    - minimal effort required to avoid penalty in 2019
  - **Additional performance threshold:** 70
Quality Reporting Take Home

• Satisfactory participation is required to avoid penalties, maximize reimbursements and ensure access to patients

• The better your performance, the better your chances for increased reimbursements in the future

• Providers who proactively work toward not only satisfying reporting requirements, but also excelling, will be well-positioned for future success

But How?
But How?

- If not using an electronic health record, start/continue researching options
  - ACI (MU) will be 25% of your composite score in 2019 (based on 2017)
  - Quality (PQRS) will be 60% of your composite score in 2019

- If using an electronic health record, engage with your vendor about quality reporting
RevAspire is a technology-enabled service that supports, equips and assists customers through the entire process of CMS quality reporting.

RevAspire frees you and your staff from the administrative burden of submitting quality reporting data and equips customers with one-on-one support to not just meet CMS quality reporting requirements, but to exceed them.

Three primary services:

1. Quality Reporting Data Submission
2. Personal Quality Reporting Advisor
3. Quality Reporting Audit Response Assistance
Questions?

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