Ohio Optometric Association
Practice Management Institute 2018

MACRA/MIPS:
Everything You Need to Know to Succeed

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.

Jay W. Henry, O.D., M.S.

Where to go for Help, Handouts, and Future Updates

Game Plan

- MACRA / Quality Payment Program Overview
- MIPS in Detail
  - Quality
  - Cost
  - Clinical Practice Improvement Activities (CPIA)
  - Advancing Care Information (ACI)
- MIPS Changes for 2018
  - What you need to know to succeed in 2018
- Questions

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

3 Goals for our health care system

Medicare Payment **Prior** to MACRA

- Prior to MACRA Medicare payments were based on a Fee-for-service (FFS) system
  - Clinicians were paid based on **volume** of services not **value**
- **The Sustainable Growth Rate (SGR)**
  - Established in 1997 to control the cost of Medicare payments

Medicare Payment Prior to MACRA

- The SGR was used to match the target Medicare budget to Physician payments
  - This was done via adjustments to the physician fee schedule for the following year
  - Many years this adjustment would have meant a 21-27% payment reduction in the physician fee schedule
  - Each year congress would pass temporary "doc fixes" to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments in 2016)
  - The continual need for "doc fixes" led to the repeal of the SGR in 2015
- **MACRA replaces the SGR with a more predictable payment method that incentivizes value**

The Quality Payment Program (QPP)

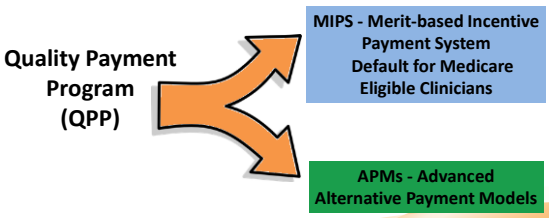
- CMS is calling the new program under MACRA the **Quality Payment Program** (QPP)
  - QPP takes a comprehensive approach to payment by basing consideration of quality on a set of evidenced-based measures that were primarily developed by clinicians
  - QPP encourages improvement in clinical practice
  - QPP is supported by advances in technology that allow for the easy exchange of information

The Quality Payment Program (QPP)

The Quality Payment Program policy will:

- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:



Benefits of the Quality Payment Program

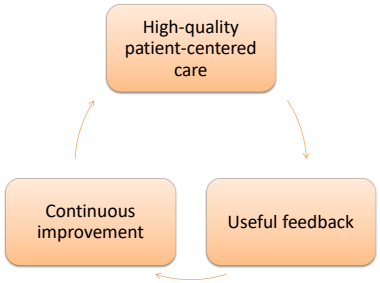
Clinicians

- Streamlines reporting
- Standardizes measures
- Eliminates duplicative reporting
- Allows clinicians more time with patients
- Incentivizes care that focuses on improved quality outcomes

Patients

- Increases access to better care
- Enhances coordination through a patient-centered approach
- Improves results

Quality Payment Program



Quality Payment Program Goals

- Improve beneficiary outcomes
- Increase adoption of Advanced APMs
- Improve data and information sharing
- Enhance clinician experience
- Maximize participation
- Ensure operational excellence in program implementation

What Does the Quality Payment Program Do?

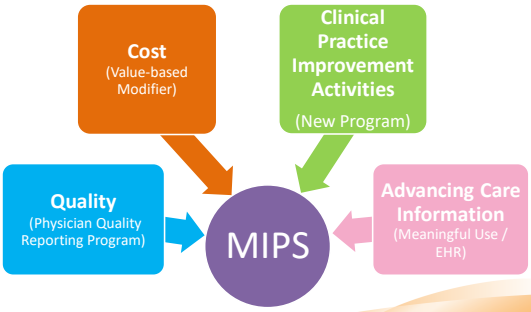
- **QPP creates Medicare payment methods that promote quality over volume by:**
  - Repealing the SGR
  - Creating two tracks:
    - MIPS: Merit-Based Incentive Payment System
    - Advanced APMs: Advanced Alternative Payment Models
  - Streamlining legacy programs
  - Establishing PTAC
    - The Physician-focused Payment Model Technical Advisory Committee

Merit-Based Incentive Payment System (MIPS)

Merit-based Incentive Payment System

- MIPS is the first step toward an outcome-based and performance-based payment system
  - Ends paying clinicians more based on the number of treatments, visits, procedures, and tests completed
  - Will pay more for better outcomes that are delivered with less time and cost to the patient and health care system
    - The good work that clinicians do is not limited to conducting tests or writing prescriptions, but also taking the time to have a conversation with a patient about test results, being available to a patient through telehealth or expanded hours, coordinating medicine and treatments to avoid confusion or errors, and developing care plans
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice

Merit-based Incentive Payment System (MIPS)



Merit-based Incentive Payment System

- Performance Category Weights
  - Weights assigned to each category based on a 1 to 100 point scale

Merit-based Incentive Payment System

- What if you don't have an Certified EHR system?
  - You can still participate in MIPS but your ACI score will be 0%

Merit-based Incentive Payment System

What is the Performance Period for MIPS in **2018**

- Minimum **90-day** performance period for:
  - Advancing Care Information
  - Improvement Activities
- Minimum **12 month** performance period for:
  - Quality
  - Cost

Merit-based Incentive Payment System

How is MIPS tracked via TINs and NPIs

- Individuals: If you participate in MIPS as an individual CMS will use both your TIN and NPI
  - If you practice in more than 1 location or you move to a new practice you will be assessed separately for each TIN your NPI is linked to
- Groups: if you choose to participate jointly as a group the group's TIN alone will be your identifier for all performance categories

Merit-based Incentive Payment System

Bonuses and Penalties:

- Payment adjustments will be applied at the TIN/NPI level regardless of whether you participate in MIPS as an individual or as part of a MIPS group

Merit-based Incentive Payment System

- Your final MIPS score will follow you to your next practice
  - Your 2018 final score will impact your 2020 payments even if you move to a new practice
  - Your 2017 final score will impact your 2019 payments even if you move to a new practice

Overview of Merit-Based Incentive Payment System for 2018

2018 MIPS Information

The Quality Payment Program (QPP) Year 2

- For Year 2 feedback was utilized and is being used to ensure that:
  - The program's measures and activities are meaningful
  - Clinician burden is minimized
  - Care coordination is better
  - Clinicians have a clear way to participate in Advanced APMs

2018 MIPS Information

- For Year 2 the QPP will keep:
  - Going slow while preparing clinicians for full implementation in year 3
  - Providing more flexibility to help reduce your burden
  - Offering new incentive for participation
- CMS is continuing to look for ways to reduce the clinicians burden and simplify the program

2018 MIPS Information

Goals of 2018 QPP Year 2 Program:

1. To improve beneficiary outcomes and engage patients through patient-centered Advanced APM and MIPS policies
2. To enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools
3. To increase the availability and adoption of robust Advanced APMs
4. To promote program understanding and maximize participation through customized communication, education, outreach and support that meet the needs of the diversity of physician practices and patients, especially the unique needs of small practices

2018 MIPS Information

Goals of 2018 QPP Year 2 Program:

5. To improve data and information sharing on program performance to provide accurate, timely, and actionable feedback to clinicians and other stakeholders
6. To deliver IT systems capabilities that meet the needs of users for data submission, reporting, and improvement and are seamless, efficient and valuable on the front and back-end
7. To ensure operation excellence in program implementation and ongoing development; and to design the program in a manner that allows smaller independent and rural practices to be successful.

Overview of Merit-Based Incentive Payment System Categories

MIPS: Quality Category Overview

- 2018 Quality Category Requirements:
  - Replaces PQRS and Quality portion of the Value Modifier
  - Select 6 of about 270 quality measures
    - 1 measure must be:
      - Outcome measure OR
      - High-priority measure – defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination
      - May also select specialty-specific set of measures
      - 12 month quality performance period (Jan 1 – Dec 31 2018)

50 % of final score

MIPS: Advancing Care Information Category Overview

- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (Medicare Meaningful Use)
  - If you have already started the Medicaid EHR incentive program (last year to start was 2016) it continues for 6 years or until 2021
- Greater flexibility in choosing measures

25 % of final score

MIPS: Advancing Care Information Category Overview

- In 2018, there are **2 measure sets for reporting based on EHR edition:**
  1. Advancing Care Information Objectives and Measures
  2. 2018 Advancing Care Information Transition Objectives and Measures
- The 2018 Transition Objectives and Measures will be the easier route for clinicians

25 % of final score

MIPS: Improvement Activities Category Overview

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- Clinicians choose from 100+ activities under 9 subcategories:
  1. Expanded Practice Access
  2. Population Management
  3. Care Coordination
  4. Beneficiary Engagement
  5. Patient Safety and Practice Assessment
  6. Participation in an APM
  7. Achieving Health Equity
  8. Integrating Behavioral and Mental Health
  9. Emergency Preparedness and Response

15 % of final score

MIPS: Improvement Activities Category Overview

- Reporting Criteria for 2018
- You must attest by indication "yes" to each activity that meets the 90 day requirement (activities that you performed for at least 90 consecutive days)
  - You may report activities using:
    - Qualified registry
    - EHR technology
    - Qualified clinical data registry (QCDR)
    - CMS Web interface (groups of 25 or more)
    - Attestation via Quality Payment Program Website
  - You may choose to attest to the activities that are most meaningful to your practice
    - No subcategory reporting requirements

MIPS: Cost Category Overview

Why focus on Cost:

- Measuring cost is an important part of MIPS because cost measures show:
  - The resources clinicians use to care for patients
  - The Medicare payments for care given to beneficiary during an episode of care
- For 2018 MIPS uses cost measures that cover the total cost of care during the year or during a hospital stay
- Cost uses Medicare claims data to collect the cost information, therefore **you don't have to submit any extra data for the cost category**
- 10% of final score in 2018

10% of final score

MIPS: Cost Category Overview

- Cost uses measures previously used in the Physician Value-Based Modifier program
  - These are reported in the Quality and Resource Use Report (QRUR)
- To understand your Cost performance you must download your Quality and Resource Use Report

10% of final score

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 (formerly PQRS)
  2. Advancing Care Information (formerly Meaningful Use)
  3. Cost (formerly VM)
  4. Practice Improvement Activities (new program)

Calculating the Final Score Under MIPS

Final Score =

Quality performance category score x actual Quality performance category weight

+

Cost performance category score x actual Cost performance category weight

+

Improvement Activities performance category score x actual Improvement Activities performance category weight

+

Advancing Care Information performance category score x actual Advancing Care Information performance category weight

x 100

Payment Adjustments

2017 Performance Year

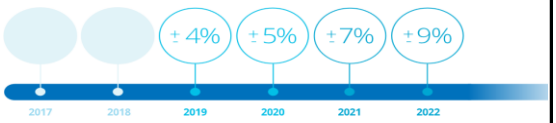
Final Score	Payment Adjustment
≥ 70 points	• Positive adjustment • Eligible for exceptional performance bonus
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

2018 Performance Year

Final Score	Payment Adjustment
≥ 70 points	• Positive adjustment • Eligible for exceptional performance bonus
15.01-69.99 points	• Positive adjustment • Not eligible for exceptional performance bonus
15 points	• Neutral payment adjustment
3.76 – 14.99 points	• Negative payment adjustment between 0 – 4.99%
0 – 3.75 points	• Negative payment adjustment of -5%

Payment Adjustments

- The Quality Payment Program will have larger payment adjustments both positive and negative each year



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 extra 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 – Getting Started!

Getting Started with MIPS in 2018

- ❑Determine your eligibility status for 2018
- ❑Choose if you will be reporting as an individual, group, or virtual group
- ❑Decide if you will work with a third party intermediary
- ❑Review the performance period for each category
- ❑Review the program timeline for dates
- ❑Assess your Feedback from QPP website and QRUR Reports

MIPS Eligible Clinicians

- Are you Eligible?
- You must answer **YES** to these 3 questions:
  1. Are you a Physician (Optometrist), Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, or Certified Registered Nurse Anesthetist?
  2. Do you bill Medicare Part B $90,000 or more per year?
  3. Do you have 200 or more Medicare patients per year?

- If you answered YES to the above 3 questions you are qualified to participate in MIPS

MIPS Excluded Clinicians

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until the following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to $90,000 a year

OR

- See 200 or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of your Medicare payments

OR

- See 20% of your Medicare patients through an Advanced APM

How to Find Your MIPS Eligibility Status

CMS MIPS Participation Status Tool

- Web based tool from CMS to determine if you are required to participate in MIPS
- You will need your NPI number
- https://qpp.cms.gov/participation-lookup

MIPS Participation Status

Enter your 10-digit National Provider Identifier (NPI) number to view your MIPS participation status by Performance Year (PY).

NATIONAL PROVIDER IDENTIFIER (NPI)

Check All Years

PY 2017 PY 2018

2018 Participation Status

NPI: #1295771939

The first review of Performance Year 2018 is now available. If you're exempt from MIPS, you won't need to do anything for MIPS for Performance Year 2018. Learn more about MIPS participation.

Included in MIPS

PHILIP JAMES GROSS must submit data for MIPS by March 2019. This clinician will need to report as an individual or with a group.

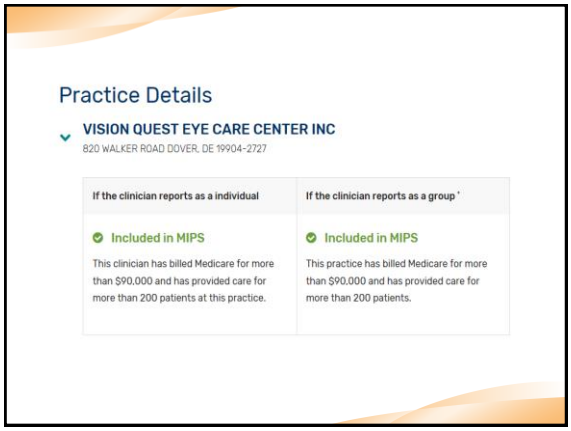
What Can I Do Now?

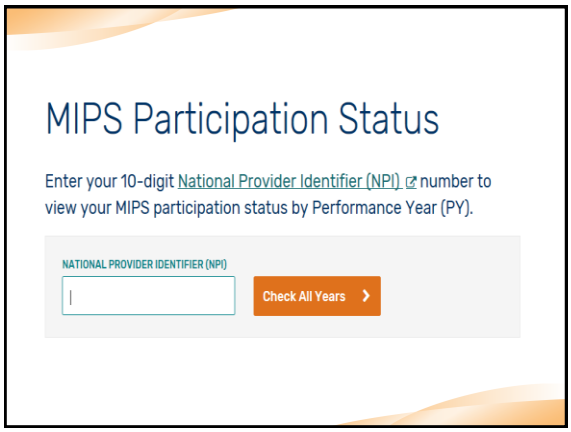
Clinician Details

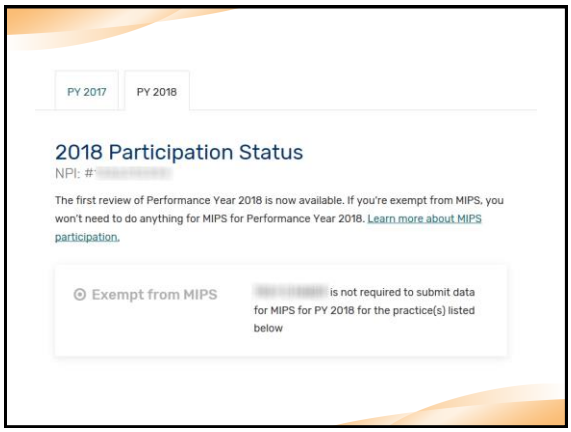
PHILIP JAMES GROSS, OD

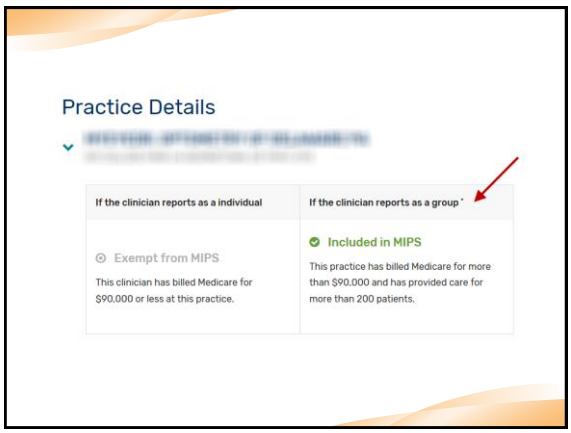
NPI: #1295771939

Provider Type	Doctor of Optometry
Associated TINs	1
Enrolled in Medicare Before January 1, 2018	Yes









Getting Started with MIPS in 2018

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MIPS: Participating as an Individual or Group

Reporting as an individual

- Your payment adjustment will be based on your performance (based on individual NPI)
- You will send your individual data for each MIPS category through an EHR, registry, or qualified clinical data registry. You may also send in quality data through your routine Medicare claims process

Reporting as a group or virtual group

- The group will get one payment adjustment based on the group's performance. A group is defined as a set of clinicians (Identified by NPI) sharing a common TIN, no matter the specialty or practice site
- Your group will send in group-level data for each MIPS category through CMS web interface or an EHR, registry, or a qualified clinical data registry
- To submit data through CMS web interface (for groups and virtual groups ≥ 25 eligible clinicians only), you must register to us the CMS Web interface between April 1 - June 30, 2018
- Virtual groups had to be created between Oct 11, 2017 – Dec 31, 2017

MIPS: Reporting Options

OPTIONS

Individual	Group
1. **Individual**—under an NPI number and TIN where they reassign benefits	2. As a Group a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN* b) As an APM Entity

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

How to Submit your MIPS Data to CMS

	Individual	Group
Quality	✓ QCDR *(Qualified Clinical Data Registry)* ✓ Qualified Registry ✓ EHR ✓ Claims	✓ QCDR *(Qualified Clinical Data Registry)* ✓ Qualified Registry ✓ EHR ✓ Administrative Claims ✓ CMS Web Interface (groups of 25 or more) ✓ CAHPS for MIPS Survey
Advancing Care Information	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ CMS Web Interface (groups of 25 or more)
Improvement Activities	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor

Getting Started with MIPS in 2018

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Working with a Third Party Intermediary

Intermediary	Approval Needed	Cost to Clinician
EHR Vendor	EHR Vendors Must be certified by ONC	x
QCDR	QCDRs must be approved by CMS	x
Qualified Registry	Qualified Registries must be approved by CMS	x
CMS Approved CAHPS Vendor	CAHPS Vendors must be approved by CMS	x

Merit-Based Incentive Payment System (MIPS): 2017 CMS-Approved Qualified Clinical Data Registries (QCDRs)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) streamlined a collection of quality programs into a single system where Medicare physicians and other clinicians have a chance to be rewarded for better care. There are two paths in the Quality Payment Program:

- Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)

Under MIPS, there are four performance categories- Quality, Clinical Practice Improvement Activities (referred to as "Improvement Activities"), meaningful use of certified EHR technology (referred to as "Advancing Care Information"), and Resource Use (referred to as "Cost").

QCDR Name	Contact Information	Cost	Submission Options Supported	Services Offered	Performance Categories Supported	MIPS Quality Measures Supported	QCDR Measures Supported (Formally referred to as non-MIPS measures)	eCQMs Supported
AOA MORE - Measures and Outcomes Registry for Eyecare	243 N. Lindbergh Blvd St. Louis, MO 63141 QualityImprovement@aoa.org 800-365-2219 www.aoa.org	Included as an AOA member benefit; $1,800 per year for non-members	Individual MIPS clinicians, Groups	AOA MORE will provide: • Data Collection • Quality Payment Program support • Data analysis of clinical outcomes for the benefit of improving care • Demographic analysis to ensure greatest patient access to care • Benchmarking against national performance rates of all registry participants (dashboards updated weekly) o QPP measures o Diagnoses o Procedures o Demographics AOA MORE will support individual and GPRO reporting. Enroll at www.aoa.org/MORE	Improvement Activities, Quality	Q012, Q019, Q117, Q130	None	Q001, Q012, Q018, Q019, Q117, Q130, Q226, Q236, Q374

Getting Started with MIPS in 2018

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Performance Periods for MIPS 2018

- Minimum **90-day** performance period for:
  - Advancing Care Information
  - Improvement Activities
- Minimum **12 month** performance period for:
  - Quality
  - Cost

Getting Started with MIPS in 2018

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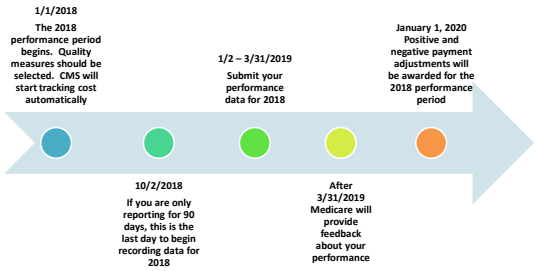
2018 MIPS Timeline



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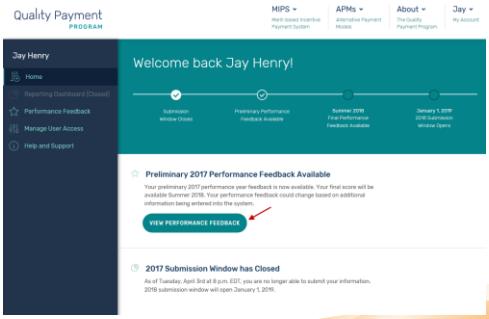
Performance Data on CMS QPP Website



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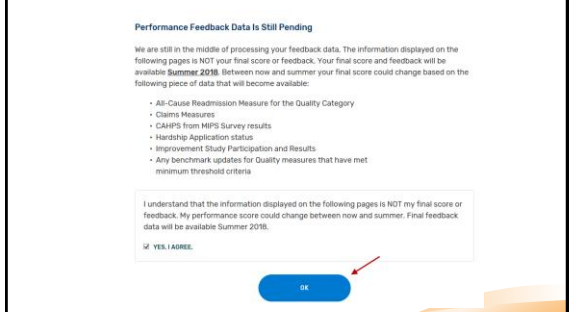

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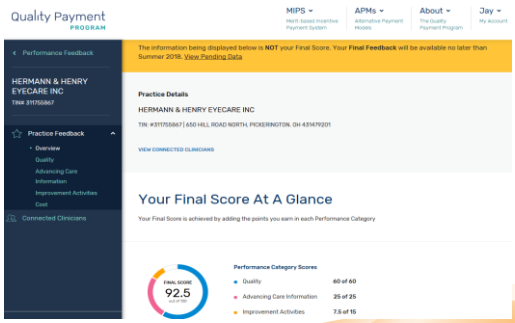

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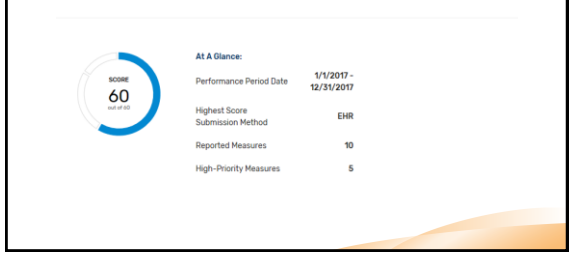

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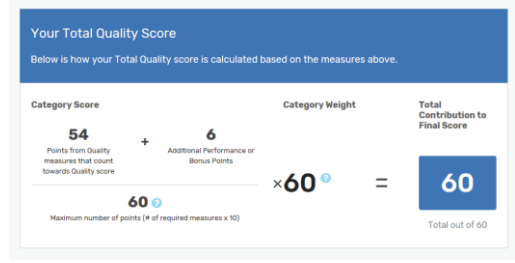

Performance Data on CMS QPP Website

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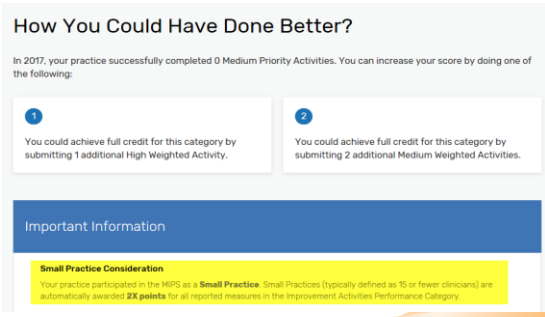
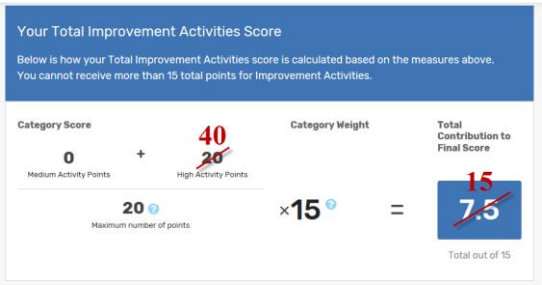
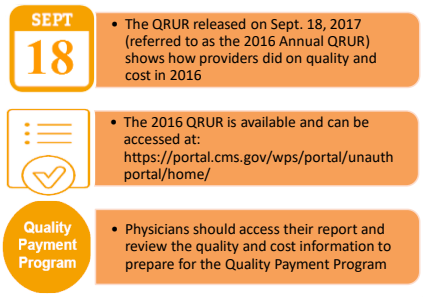


Performance Data on CMS QPP Website



Access Your Feedback Report: Prepare for the Following Year



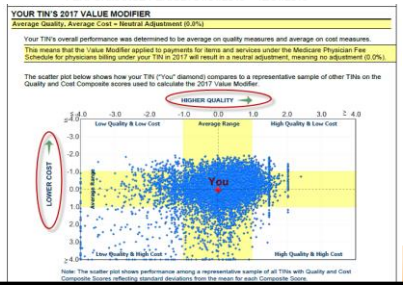
Quality & Resource Use Reports

Quality and Resource Use Report DOWNLOAD THEM

- Quality and Resource Use Report (QRUR)
- Download your 2016 annual report now to understand your TIN's current quality and cost performance
- Review quality measures benchmarks and your performance

QRUR Report

2015 ANNUAL QUALITY AND RESOURCE USE REPORT
AND THE 2017 VALUE-BASED PAYMENT MODIFIER
Sample Medical Practice A
LAST FOUR DIGITS OF YOUR MEDICARE-ENROLLED TAXPAYER IDENTIFICATION NUMBER (TIN): 0000
PERFORMANCE PERIOD: 01/01/2015 – 12/31/2015



QRUR Report

- This shows you your "Value" which will become part of the MIPS Cost Category

The Value Modifier calculated for your TIN is shown in the highlighted cell in Exhibit 1. The Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%).

Exhibit 1. 2017 Value Modifier Payment Adjustments under Quality-Tiering
(TINs with 10 or More Eligible Professionals)

	Low Quality	Average Quality	High Quality
Low Cost	0.0%	+2.0 x AF	+4.0 x AF
Average Cost	-2.0%	0.0%	+2.0 x AF
High Cost	-4.0%	-2.0%	0.0%

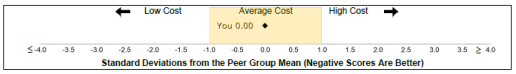
QRUR Report

- This shows your "Cost" score which is also part of the MIPS Cost category score

PERFORMANCE ON COST MEASURES

Your TIN's Cost Tier: Average

Exhibit 4. Your TIN's Cost Composite Score



QRUR Report

- This shows how you did on certain Quality measures which will be used to calculate your MIPS Quality score

Measure Identification Number(s)	Measure Name	Your TIN				All TINs in Peer Group	
		Number of Eligible Cases	Performance Rate	Standardized Performance Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
130 (GPRO Care-3, CMS68v4)	Documentation of Current Medications in the Medical Record	0	0.00%	0.00	No	0.00%	0.00
318 (GPRO Care-2, CMS139v3)	Falls: Screening for Fall Risk	0	0.00%	0.00	No	0.00%	0.00

How to Obtain a QRUR

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

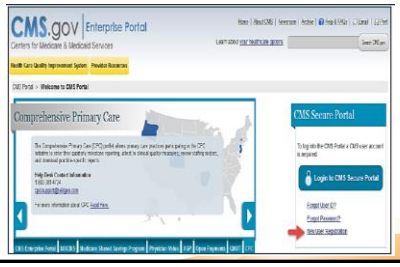
QRUR Report – GET THEM!

- Must have an EIDM account with a Physician Quality and Value Programs Role
- Follow the steps in this guide to set up your account at

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html

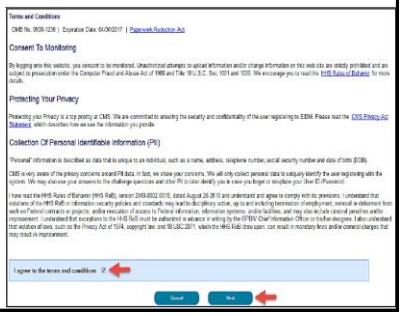
Setting up your EIDM Account

- Visit website https://portal.cms.gov and select New User Registration



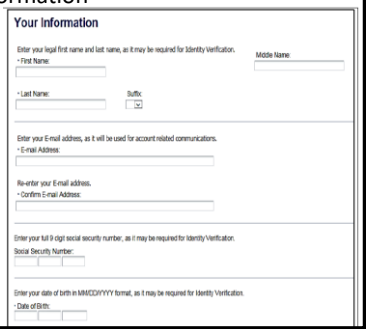
Setting up your EIDM Account

- Accept terms and conditions



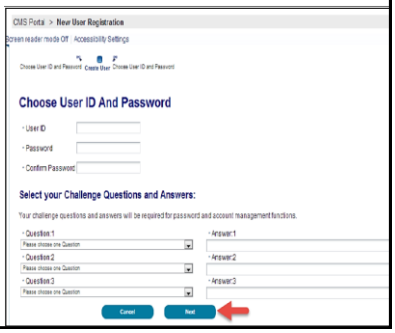
Setting up your EIDM Account

- Enter your information



Setting up your EIDM Account

- Create your User ID and Password



Setting up your EIDM Account

- Use your newly created account to login

Setting up your EIDM Account

- Request Access Now then select My Access

Setting up your EIDM Account

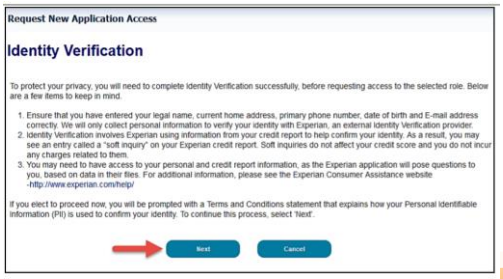
- Request Access for Physician Quality and Value Programs

Setting up your EIDM Account

- Select your role

Setting up your EIDM Account

- Complete the identity verification process



Setting up your EIDM Account

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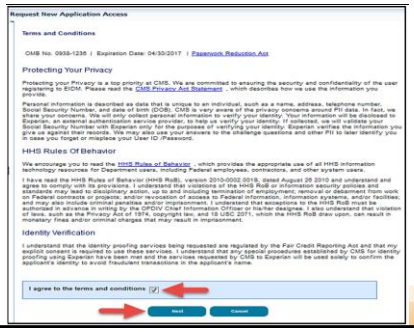

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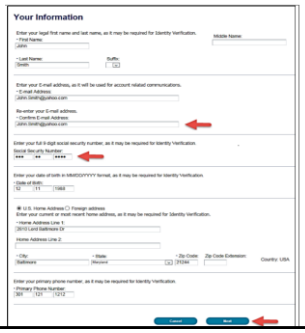

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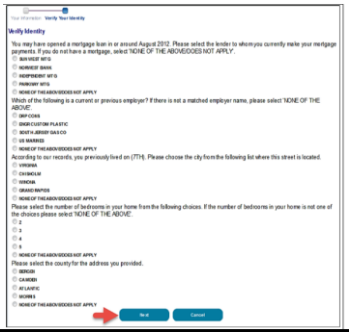
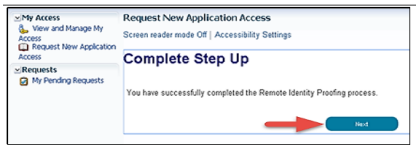


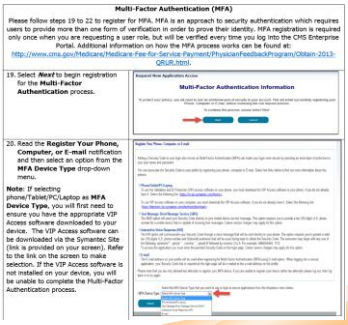
Setting up your EIDM Account

- Complete the identity verification process



Setting up your EIDM Account

- Setup multi-factor Authentication

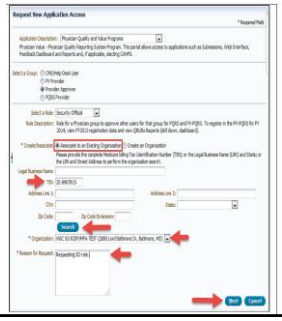


Setting up your EIDM Account

- Setup multi-factor Authentication

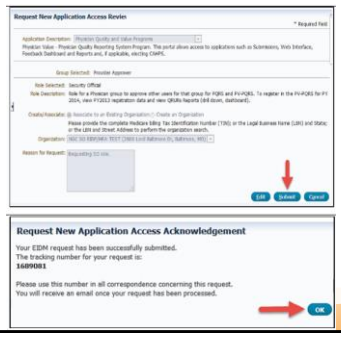
Setting up your EIDM Account

- Associate yourself to an organization or create a new organization



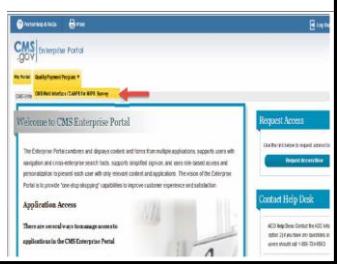
Setting up your EIDM Account

- Complete the application access process



Setting up your EIDM Account

- Once set-up is complete log in and you will be directed to CMS Portal Homepage and then select CMS Web Interface / CAHPS for MIPS survey



MIPS Scoring Calculations

CMS Bonus & Penalty Calculations

- 2018 MIPS Final Score will determine your 2020 Medicare reimbursement (up or down)
- CMS will calculate your 2018 final score which will range from 0 to 100 points
  - 2018 Composite score based on 4 categories
    - Quality 50%
    - Advancing care information 25%
    - Improvement activities 15%
    - Cost 10%

CMS Bonus & Penalty Calculations

- CMS will check if your 2017 final score exceeds, meets, or falls below the 3-point performance threshold
  - **Bonus:** Exceed the 15 point payment adjustment threshold, and you can expect a small positive payment adjustment
  - **Exceptional performance bonus:** Meet or exceed the 70 point additional performance threshold, and you will receive an additional payment adjustment factor
    - Taps you into a $500 million dollar annual bonus pool!

Advanced Alternate Payment Models (APMs)

MACRA
Pathway #2: Alternate Payment Models (APMs)

- APMs are new approaches to paying for medical care through Medicare that **incentivize quality and value**
- APM participants who are not using eligible APMs will receive favorable scoring under MIPS clinical practice improvement activities category plus APM specific rewards
- As defined by MACRA APMs Include:
  - CMS Innovation Center Model
  - Medicare Shared Savings Program (MSSP)
  - Demonstration under the Health Care Quality Demonstration Program
  - Demonstration required by federal law

MACRA – Alternate Payment Models

- Only some APMs will be considered **"Eligible APMs"**
- Eligible APM entities
  - Most Advanced APMs
  - Require the use of certified EHR technology
  - Provide for payment for covered professional services based on quality measures comparable to those measures in MIPS performance category
  - Participants must bear financial risk for monetary losses under the APM that are in excess of a nominal amount or are medical homes

MACRA – Eligible APMs Participation

- Qualifying APM participants (QPs)
  - Physicians who have a certain **% of their patients or payments** through an **eligible APM**
  - QPs are not subject to MIPS
  - Receive 5% lump sum **bonus payments** for years 2019-2024
  - Receive a **higher fee schedule update** for 2026 onward

MIPS – Performance Categories The Details

Understanding the MIPS Performance Categories

Detailed look

Quality

2018 MIPS: Quality

- Remember replaces PQRS and Quality portion of Value Modifier
- 50% of final MIPS score = 60 points
- Select 6 of 270 quality measures
  - 1 must be outcome measure or high-priority measure
- Groups (25 or more providers) using the web interface report 15 quality measures
- Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks
- Failure to submit performance data for a measure = 0 points
- Bonus Points are available

50 % of final score

2018 MIPS: Quality

Bonus Points:

- Starting in 2018 you can earn up to 10 percentage points as bonus points based on the rate of your improvement in the Quality performance category from the year before
- You will receive 1 bonus point per measure for reporting your quality data directly from your EHR to a qualified registry, QCDR, or via CMS Web interface
- You will receive 1 bonus point for each additional high priority measure, and 2 bonus points for each additional outcome and patient experience measure submitted

MIPS: Quality

Steps to get the most points under Quality Category

- Select a Reporting Mechanism
  - If you don't have a Certified EHR you can report via claims based reporting as an individual **(not available to groups)**
  - If you have an EHR you can report via:
    - EHR Vendor Direct
    - AOA More
  - Large Practice (25 or more providers) can report via the CMS Web Interface
- **Your choice of reporting mechanism will determine which quality measures you can report**
- Select the one reporting mechanism that best fits your practice needs

MIPS: Quality

- **What if you use more than 1 reporting mechanism?**
  - Suppose you use both claims and EHR vendor to report quality measures
  - CMS **will not** give you an aggregate score that combines claims based submission with EHR based submission
  - CMS **will** assess your score for both claims based and EHR based submission and assign you the higher score

MIPS: Quality

- AOA More - Supported EHR Integrations as of January 2018

Compulink

The December 28, 2017 release of Compulink Advantage Version 12.0.x.x. gives Compulink the distinction of being the first of the AOA MORE EHR Partners to achieve *ONC 2015 Edition certified CEHRT* status! In order to have your 2017 data submitted to AOA MORE in time for the March 2018 reporting deadline, please update to Compulink Version 12, 2015 CEHRT Edition as soon as possible. This update will allow Compulink AOA MORE clients access to seamless integration of Quality Reporting data for the entire 2017 reporting year (January 1-December 31, 2017). Doctors will transition to the 2016 Quality Reporting Performance Year while Compulink EHR data is communicated on a weekly basis with the AOA MORE dashboard.

Compulink ONC 2015 Edition will allow doctors of optometry to earn bonus incentive payments recently announced by CMS tied to exclusive use of 2015 Edition CEHRT. Download this update as soon as possible for access to the newest features and AOA integration available to your practice. See detailed instructions on the Compulink Advantage website under 'What's New V12' to expedite your retrieval of this new release.

Crystal Practice Management

AOA MORE will be able to report at least one quality measure for some doctors AND support two clinical practice improvement activities for all doctors. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

MIPS: Quality

- AOA More - Supported EHR Integrations as of January 2018

MaximEyes EHR

MaximEyes encourages their users to submit 2017 quality measures via MaximEyes EHR. No quality measures will be reported by AOA MORE for 2017. For additional information on how MaximEyes EHR can support you in meeting quality measure requirements, please contact MaximEyes at 800.920.1940, Ext. 6633 or email joakiml@first-insight.com. To access comprehensive training guides, log in to MaximEyes For Customers website at https://customer.first-insight.com, click the "Training Resources" tab then navigate to the Incentive Program Resources section. AOA MORE can also support two clinical practice improvement activities for doctors. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

OfficeMate ExamWRITER

AOA MORE will be able to report at least one quality measure AND support two clinical practice improvement activities for doctors. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

Eyefinity EHR

Eyefinity EHR has successfully and fully executed the AOA MORE integration for the 2017 reporting year. Effective Tuesday evening, December 26th, the Eyefinity® EHR and AOA MORE integration will be complete, allowing doctors to submit all MIPS quality measures for the 2017 reporting year.All finalized exam data from January-December 2017 will automatically be pushed to the AOA MORE registry weekly, every Friday. AOA MORE can also support clinical practice improvement activities. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

MIPS: Quality

- AOA More - Supported EHR Integrations as of January 2018

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Practice Director

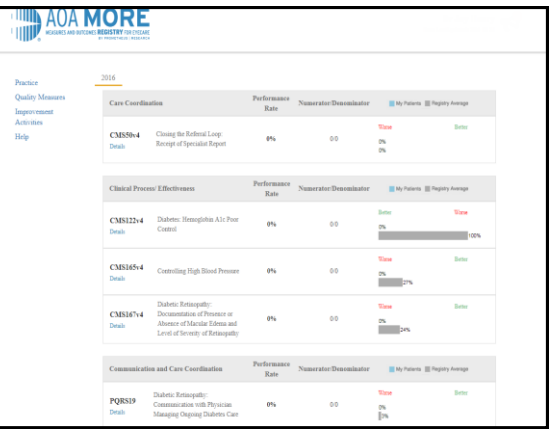
Practice Director has successfully and fully executed AOA MORE integration for the 2017 reporting year. AOA MORE also supports two clinical practice improvement activities for doctors. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

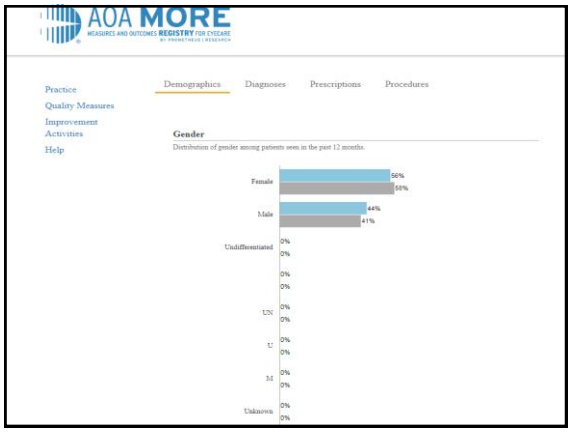
RevolutionEHR

RevolutionEHR has not submitted live production data to AOA MORE in 2017. For additional information on how RevolutionEHR can support you in meeting quality measure requirements, please contact RevolutionEHR at: aoamore@revolutionehr.com. AOA MORE can also support two clinical practice improvement activities for doctors. For guidance on completing CPIAs via AOA MORE review page 3 of the Merit-Based Incentive Payment System Guidebook Evaluating and Tracking Your Progress

FUTURE INTEGRATIONS:

FoxFire LiquidEHR Uprise





Claims Based Reporting of MIPS Quality Measures

Claims Reporting is only available for MIPS Individuals not for MIPS groups

Dx A: H35.3111 (early dry AMD right eye)	Dx B:			
Date Service	**Place Service**	**Procedure (CPT I) and QDC (CPT II)**	**Procedure Description**	**Dx**
1/14/2018	11	92014	Exam	1
1/14/2018	11	92015	Refraction	1
1/14/2018	11	2019F	Dilated Macular Exam Performed including documentation of macular thickening or hemorrhage and the level of macular degeneration severity	1

EHR Reporting of MIPS Quality Measures

MIPS: Quality

Scoring

- Your performance rate will be compared against a benchmark (if one exists)
- Provided that a measure has a benchmark you can attain 3-10 points <u>if you meet the data submission thresholds</u>
  - **If there is not a benchmark then you can only receive a maximum of 3 points**

MIPS: Quality

- **Quality submission thresholds and data completeness**
  - To be eligible to receive more than 1 point (3 for small practices) a quality measure must meet both the case minimum requirement and the data completeness criteria
    1. **Case minimum requirement is 20 patients**
       - You must report the measure on at least 20 unique patients
    2. **Data completeness criteria is reporting on at least 60% of applicable patients and at least 1 Medicare patient**
       - For each measure you report, submit data on at least 60% of applicable patients seen during the reporting period
       - Applicable patients:
         - » When submitting via claims is Medicare patients
         - » When submitting via Registry or EHR vendor is all patients both Medicare and Non-Medicare for whom the measure applies

MIPS: Quality

- Your score (3-10 points) will depend on how your performance compares against the benchmark
  - There are separate benchmarks for each reporting mechanism (claims based, AOA more, EHR vendor) for the exact same Quality measures
  - These benchmarks are based on performance data drawn from <u>all clinicians who use the measure</u> (typically using data from 2 years prior)

MIPS: Quality

- Each benchmark is broken into deciles and the number of points you receive will depend on which of the deciles you fall into
- Benchmarks can be found online

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Quality-Benchmarks.zip

MIPS: Quality

- Understanding Benchmarks
  - Each benchmark is presented in terms of deciles
  - Points are awarded within each decile
  - Clinicians who receive a score in the first or second decile will receive 3 points
  - Clinicians who are in the 3rd decile will receive somewhere between 3 and 3.9 points depending on their exact position in the decile
  - Clinicians in the 4th decile will receive somewhere between 4 and 4.9 points
  - Clinicians in the 8th decile will receive somewhere between 8 and 8.9 points

MIPS: Quality

- Benchmark deciles will be different for each measure and each submission method (even for the same measure)
- Once you know your success rate on a measure (look at your EHR report or AOA MORE dashboard) you can look at the particular decile table for that measure and the submission method you will be using to determine how many points you will receive for that specific measure

MIPS: Quality

Decile	Benchmark % (Different for each measure/ submission method)	Number of Points Assigned for 2018 MIPS Performance Period
Below Decile 3		3 points
Decile 3	2.70 – 6.24	3-3.9 points
Decile 4	6.25 – 11.46	4-4.9 points
Decile 5	11.47 – 18.15	5-5.9 points
Decile 6	18.16 – 25.57	6-6.9 points
Decile 7	25.58 – 36.95	7-7.9 points
Decile 8	36.96 – 51.17	8-8.9 points
Decile 9	51.18 – 71.87	9-9.9 points
Decile 10	≥ 71.88	10 points

MIPS: Quality

- Example: You submit data on 83 patients out of 100 patients that the measure applied to
  - **Your performance score is 83% on that measure……. How many points do you get??**
  - You will receive between 5 and 5.9 points because 83% falls in the 5th decile

Decile	Benchmark	Points
3	32.26 – 48.38	3 – 3.9
4	48.39 – 71.99	4 – 4.9
5	72.00 – 84.99	5 – 5.9
6	85.00 – 89.99	6 – 6.9
7	90.00 – 97.43	7 – 7.9
8	97.44 – 99.99	8 – 8.9
9	-	-
10	100	10

MIPS: Quality

Things to watch out for when choosing Quality measures to report

- Watch for measures that **don't have benchmarks** for the reporting mechanism you are using to submit measures
  - If a measure lacks a benchmark you can't score more than 3 points for that measure
- Watch out for measures that are **topped out**
  - **CMS defines a topped out measure as a measure where the performance is consistently high across providers and meaningful distinctions and improvement in performance can no longer be made**
  - These are measures that reach or almost reach maximum performance value well before the tenth decile
  - When a measure is topped out you will need a perfect performance rate (100%) to get 10 points
  - **Even though you may have a high performance rate in a topped out measure, it will be significantly harder to earn high points for that measure**

MIPS: Quality

Example scoring on a topped out measure:

- For claims reporting: Documentation of current medications in the medical record
  - Reporting a performance rate of 99.9% would only earn 5.9 points
  - To earn 10 points the performance rate would have to be 100%

Decile	Benchmark	Points
3	97.20 – 99.23	3 – 3.9
4	99.24 – 99.79	4 – 4.9
5	99.80 – 99.99	5 – 5.9
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

MIPS: Quality

Reporting Quality Measures

- If you are reporting by claims, AOA more, or your EHR vendor maximize your payment by:
  - Report **at least** 6 quality measures
    - Suggest 8
  - Select your quality measures appropriately
    - Attempt the ones you are already performing / tracking
    - **Remember measures available to you will depend on your reporting mechanism**
  - At least 1 quality measure should be an outcome measure
    - If no outcome measure is available you must report another high priority measure instead
  - Be prepared to make changes if the measures you are tracking don't result in good numbers or the measure is topped out

MIPS: Quality

- **What if you can't report on 6 quality measures**
  - Report on as many as you can
  - You should be able to find at least 6 that are applicable
- **What if you report on more than 6 quality measures**
  - If you report on 7 or more measures, CMS will determine which 6 of those will give you the highest quality score
  - **Therefore we encourage you to report on more than 6 quality measures**

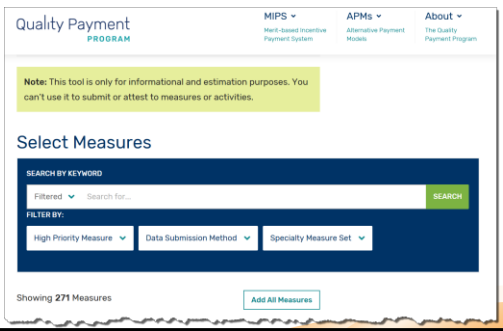
MIPS: Quality

- Picking quality measures
- CMS, under the Quality Payment Program (QPP), has developed a web based tool to help you pick quality measures

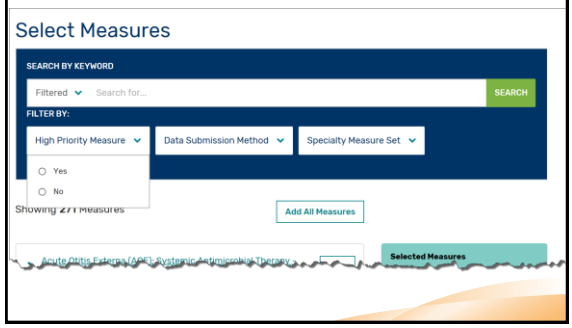
https://qpp.cms.gov/mips/quality-measures

MIPS: Quality

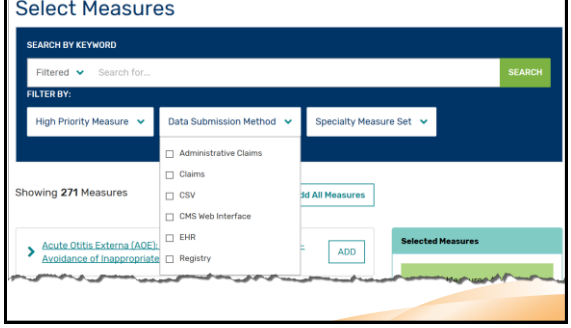
MIPS: Quality



MIPS: Quality



MIPS: Quality



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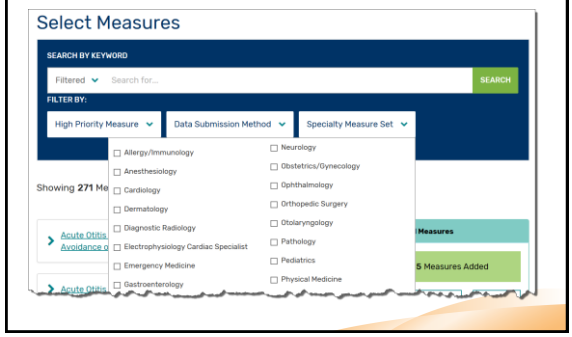
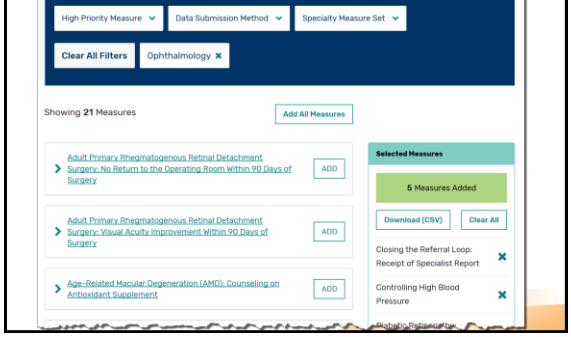


MIPS: Quality



MIPS: Quality Scoring

- 50% of Final Score in 2018
  - Maximum score cannot exceed 100%

Total Quality Performance Category Score = [Points earned on required 6 quality measures] + [Any bonus points] / Maximum number of points*

*Maximum number of points = # of required measures x 10

MIPS: Quality Scoring

Possible Quality Measures:

- AMD: Counseling on Antioxidant Supplement (claims / registry reporting only)
  - Percentage of patients aged 50 years and older with a diagnosis of AMD 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
- AMD: Dilated Macular Exam (claims / registry reporting only)
  - Percentage of patients aged 50 years and older with a diagnosis of AMD who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months
- Closing the Referral Loop: Receipt of Specialist Report (EHR / registry reporting) *
  - Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred
- Diabetes: Eye Exam (Claims, EHR, registry reporting)
  - Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period
- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (Claims, EHR, registry reporting) *
  - Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

*** High Priority Measures**

MIPS: Quality Scoring

Possible Quality Measures:

- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy (EHR / registry reporting)
  - Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months
- Documentation of Current Medications in the Medical Record (Claims, EHR, registry reporting) *
  - Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration
- Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan (Claims, EHR, registry reporting)
  - Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Claims, EHR, registry reporting)
  - Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

*High Priority Measures

MIPS: Quality Scoring

Possible Quality Measures:

- Primary Open-Angle Glaucoma: Optic Nerve Evaluation (Claims, EHR, registry reporting)
  - Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months
- Primary Open-Angle Glaucoma: Reduction of IOP by 15% or documentation of a plan of care (Claims, registry reporting)
  - Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months
- Use of High-Risk Medications in the Elderly (EHR, registry reporting) *
  - Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (EHR / registry reporting)
  - Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity

*High Priority Measures

MIPS: Quality

AOA More supported Quality Measures

CMS68	Documentation of Current Medication
CMS131	Diabetes: Eye Exam
CMS50	Closing the Referral Loop: Receipt of Specialist Report
CMS142	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
CMS143	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
CMS167	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
CMS 138	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
CMS 165	Controlling High Blood Pressure
CMS 122	Diabetes: Hemoglobin A1c Poor Control

MIPS: Quality

Common Measure Benchmarks

AMD – Counseling AREDS: Claims Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	97.33 – 99.99	3 – 3.9
4	-	-
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

AMD – Counseling AREDS: Registry Reporting

- **Benchmark: Yes** **Topped Out : No**

Decile	Benchmark	Points
3	35.90 – 57.88	3 – 3.9
4	57.89 – 71.75	4 – 4.9
5	71.76 – 86.38	5 – 5.9
6	86.39 – 94.22	6 – 6.9
7	94.23 – 98.31	7 – 7.9
8	98.32 – 99.99	8 – 8.9
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

AMD – Dilated Exam: Claims Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	99.60 – 99.99	3 - 3.9
4	-	-
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

AMD – Dilated Exam: Registry Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	64.21 - 81.81	3 – 3.9
4	81.82 – 90.85	4 – 4.9
5	90.86 – 95.69	5 – 5.9
6	95.70 – 98.64	6 – 6.9
7	98.65 – 99.99	7 – 7.9
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

Closing the referral loop: EHR Vendor Reporting

- **Benchmark: Yes** **Topped Out : No**

Decile	Benchmark	Points
3	14.29 – 24.13	3 – 3.9
4	24.14 – 33.57	4 – 4.9
5	33.58 – 43.65	5 – 5.9
6	43.66 – 54.33	6 – 6.9
7	54.34 – 63.78	7 – 7.9
8	63.79 – 74.99	8 – 8.9
9	75.00 – 88.63	9 – 9.9
10	≥ 88.64	10

MIPS: Quality

Common Measure Benchmarks

Closing the referral loop: Registry Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	65.22 – 99.99	3 – 3.9
4		4 – 4.9
5		5 – 5.9
6		6 – 6.9
7		7 – 7.9
8		8 – 8.9
9		9 – 9.9
10	100	10

MIPS: Quality

Common Measure Benchmarks

Diabetes Eye Exam: EHR Vendor Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	84.83 – 92.85	3 – 3.9
4	92.86 – 95.32	4 – 4.9
5	95.33 – 96.96	5 – 5.9
6	96.97 – 98.19	6 – 6.9
7	98.20 – 99.17	7 – 7.9
8	99.18 – 99.82	8 – 8.9
9	99.83 – 99.99	9 – 9.9
10	100	10

MIPS: Quality

Common Measure Benchmarks

Diabetes Eye Exam: Registry Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	80.91 – 922.85	3 – 3.9
4	92.86 – 96.53	4 – 4.9
5	96.54 – 98.70	5 – 5.9
6	98.71 – 99.99	6 – 6.9
7	-	-
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

Diabetes Eye Exam: Claims Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	88.98 – 98.44	3 – 3.9
4	98.45 – 99.99	4 – 4.9
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

Diabetic Retinopathy – Communication with Physician managing diabetes: Claims Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	-	-
4	-	-
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

Diabetic Retinopathy – Communication with Physician managing diabetes: EHR Reporting

- **Benchmark: Yes** **Topped Out : No**

Decile	Benchmark	Points
3	46.15 – 56.85	3 – 3.9
4	56.86 – 65.13	4 – 4.9
5	65.14 – 72.38	5 – 5.9
6	72.39 – 78.21	6 – 6.9
7	78.22 – 84.27	7 – 7.9
8	84.28 – 89.93	8 – 8.9
9	89.94 – 95.41	9 – 9.9
10	≥ 95.42	10

MIPS: Quality

Common Measure Benchmarks

Diabetic Retinopathy – Communication with Physician managing diabetes: Registry Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	52 – 72.40	3 – 3.9
4	72.41 – 81.47	4 – 4.9
5	81.48 – 90.76	5 – 5.9
6	90.77 – 96.54	6 – 6.9
7	96.55 – 99.99	7 – 7.9
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

Diabetic Retinopathy – Documentation Presence / absence of Macular Edema: EHR Vendor Reporting

- **Benchmark: Yes** **Topped Out : No**

Decile	Benchmark	Points
3	57.14 – 65.83	3 – 3.9
4	65.84 – 72.72	4 – 4.9
5	72.73 – 78.21	5 – 5.9
6	78.22 – 83.12	6 – 6.9
7	83.13 – 88.17	7 – 7.9
8	88.18 – 92.30	8 – 8.9
9	92.31 – 96.32	9 – 9.9
10	≥ 96.33	10

MIPS: Quality

Common Measure Benchmarks

Documentation of current meds: Claims

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	97.20 – 99.23	3 – 3.9
4	99.24 – 99.79	4 – 4.9
5	99.80 – 99.99	5 – 5.9
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

Documentation of current meds: EHR Vendor Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	86.25 – 91.91	3 – 3.9
4	91.92 – 94.85	4 – 4.9
5	94.86 - 96.69	5 – 5.9
6	96.70 – 97.98	6 – 6.9
7	97.99 – 98.87	7 – 7.9
8	98.88 – 99.54	8 – 8.9
9	99.55 – 99.95	9 – 9.9
10	≥ 99.96	10

MIPS: Quality

Common Measure Benchmarks

Documentation of current meds: Registry Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	77.08 – 90.22	3 – 3.9
4	90.23 – 95.97	4 – 4.9
5	95.98 – 98.60	5 – 5.9
6	98.61 – 99.69	6 – 6.9
7	99.70 – 99.99	7 – 7.9
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

BMI screening and follow up: Claims Reporting

- **Benchmark: Yes** **Topped Out : No**

Decile	Benchmark	Points
3	43.20 – 48.42	3 – 3.9
4	48.43 – 58.92	4 – 4.9
5	58.93 – 83.56	5 – 5.9
6	83.57 – 96.60	6 – 6.9
7	96.61 – 99.53	7 – 7.9
8	99.54 – 99.99	8 – 8.9
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

BMI screening and follow up: EHR Reporting

- **Benchmark: Yes** **Topped Out : No**

Decile	Benchmark	Points
3	28.22 – 31.92	3 – 3.9
4	31.93 – 35.34	4 – 4.9
5	35.35 – 38.76	5 – 5.9
6	38.77 – 42.88	6 – 6.9
7	42.89 – 49.18	7 – 7.9
8	49.19 – 64.83	8 – 8.9
9	64.84 – 85.93	9 – 9.9
10	≥ 85.94	10

MIPS: Quality

Common Measure Benchmarks

BMI screening and follow up: Registry Reporting

- **Benchmark: Yes** **Topped Out : No**

Decile	Benchmark	Points
3	45.12 – 52.05	3 – 3.9
4	52.06 – 59.99	4 – 4.9
5	60.00 – 68.74	5 – 5.9
6	68.75 – 77.77	6 – 6.9
7	77.78 – 86.07	7 – 7.9
8	86.08 – 92.85	8 – 8.9
9	95.86 – 99.42	9 – 9.9
10	≥ 99.43	10

MIPS: Quality

Common Measure Benchmarks

Tobacco Use Screening and Cessation: Claims Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	96.65 – 98.59	3 – 3.9
4	98.60 – 99.61	4 – 4.9
5	99.62 – 99.99	5 – 5.9
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

Tobacco Use Screening and Cessation: EHR Vendor Reporting

- **Benchmark: Yes** **Topped Out : No**

Decile	Benchmark	Points
3	72.72 – 82.40	3 – 3.9
4	82.41 – 87.55	4 – 4.9
5	87.56 – 90.50	5 – 5.9
6	90.51 – 92.74	6 – 6.9
7	92.75 – 94.63	7 – 7.9
8	94.64 – 96.52	8 – 8.9
9	96.53 – 98.51	9 – 9.9
10	≥ 98.52	10

MIPS: Quality

Common Measure Benchmarks

Tobacco Use Screening and Cessation: Registry Reporting

- **Benchmark: Yes** **Topped Out : No**

Decile	Benchmark	Points
3	83.72 – 88.38	3 – 3.9
4	88.39 – 91.10	4 – 4.9
5	91.11 – 93.34	5 – 5.9
6	93.35 – 95.44	6 – 6.9
7	95.45 – 97.35	7 – 7.9
8	97.36 – 99.00	8 – 8.9
9	99.01 – 99.99	9 – 9.9
10	100	10

MIPS: Quality

Common Measure Benchmarks

POAG – Optic Nerve Evaluation: Claims Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	98.99 – 99.99	3 – 3.9
4	-	-
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

POAG – Optic Nerve Evaluation: EHR Vendor Reporting

- **Benchmark: Yes** **Topped Out : No**

Decile	Benchmark	Points
3	82.75 – 87.40	3 – 3.9
4	87.41 – 90.76	4 – 4.9
5	90.77 – 93.62	5 – 5.9
6	93.63 – 96.16	6 – 6.9
7	96.17 – 97.87	7 – 7.9
8	97.88 – 98.96	8 – 8.9
9	98.97 – 99.99	9 – 9.9
10	100	10

MIPS: Quality

Common Measure Benchmarks

POAG – Optic Nerve Evaluation: Registry Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	94.70 – 98.14	3 – 3.9
4	98.15 – 99.16	4 – 4.9
5	99.17 – 99.99	5 – 5.9
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

POAG – Reduction of IOP by 15% or Plan: Claims Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	-	-
4	-	-
5	-	-
6	-	-
7	-	-
8	-	-
9	-	-
10	100	10

MIPS: Quality

Common Measure Benchmarks

POAG – Reduction of IOP by 15% or Plan: Registry Reporting

- **Benchmark: Yes** **Topped Out : Yes**

Decile	Benchmark	Points
3	69.40 – 86.96	3 – 3.9
4	86.97 – 95.04	4 – 4.9
5	95.05 – 97.95	5 – 5.9
6	97.96 – 99.64	6 – 6.9
7	99.65 – 99.99	7 – 7.9
8	-	-
9	-	-
10	100	10

MIPS: Quality

- Choosing the proper measures is only part of the battle….. Reporting method is just as important in getting the best score
- **Example:** Diabetic Retinopathy – Communication with the Physician managing the Diabetes
  - If you have a performance of 96% you would earn the following score based on your reporting method:
    - Claims: 3
    - Registry: 6.9
    - EHR Direct: 10

Detailed look

Cost

MIPS: Cost

- No extra reporting requirement for cost
  - Medicare claims data will be used to calculate score
- Uses measures previously used in the Value-Based Modifier program
- Focuses on resources clinicians use to care for patients and Medicare payments given to a beneficiary during an episode of care
- 10% of final score for 2018

10% of final score

MIPS: Cost

What are the year 2018 cost measures

1. Medicare Spending Per Beneficiary Measure (MSPB) – related to services performed by clinicians immediately before, during, and after a patient's hospital stay
2. Total Per-Capita Cost Measure – measures all Medicare Part A and Part B costs during the MIPS performance period

- Cost will have a weight of 30% in 2019

MIPS: Cost

- Score for Cost category
  - Score will be calculated for you or your group's Cost performance if the case minimum of attributed beneficiaries is met
    - 20 cases for total per capita cost measure or
    - 35 cases for MSPB measure
- If case minimums aren't met for either of the two measures Cost category will get reweighted to the Quality category making Quality worth 60% (instead of 50%) of your MIPS score

Detailed look

Improvement Activities

MIPS: Improvement Activities

- Gauges your participation in activities that improve clinical practice such as:
  - Ongoing care coordination
  - Clinician and patient shared decision making
  - Regularly using patient safety practices
  - Expanding practice access
- 15% of your final score in 2018

15 % of final score

MIPS: Improvement Activities

- Attest to participation in activities that improve clinical practice
- Choose from 100+ activities from 9 subcategories to show your performance:

1. Expanded Practice Access
2. Population Management
3. Care Coordination
4. Beneficiary Engagement
5. Patient Safety and Practice Assessment
6. Participation in an APM
7. Achieving Health Equity
8. Integrating Behavioral and Mental Health
9. Emergency Preparedness and Response

15 % of final score

MIPS: Improvement Activities Scoring

- 15% Final MIPS score
- Full credit means total points obtaining 40 points in category score

Activity Weights

- Medium = 10 points
- High = 20 points

Activity Weights for small practices and rural area shortage areas

- Medium = 20 points
- High = 40 points

MIPS: Improvement Activities Scoring

- Maximum Score
  - Each improvement activity is all or nothing in score
    - Must satisfy all requirements for 90 days to get credit
  - To get the maximum score you must perform and report 1 to 4 improvement activities
    - The number of activities depends on how they are weighted and on the size and location of your practice

MIPS: Improvement Activities Scoring

- Pick you reporting mechanism for Improvement Activities
  - You can attest to your improvement activities via:
    - CMS web portal
    - EHR Vendor
- **If you use EHR to report then you may also receive the Advancing Care Information bonus for using CEHRT for improvement activities**
  - **Certain activities not only contribute to your improvement activities score but also can boost your ACI score if performed using a CEHRT**
- Performance Period for Improvement Activities = minimum of 90 consecutive days

MIPS: Improvement Activities Scoring

- 15% of Final Score in 2018
- Maximum score is 40 points cannot exceed 100%

$$\text{Improvement Activities Performance Category Score} = \left[\frac{\text{Total number of points scored for completed activities}}{\text{Total maximum number of points (40)}} \right] \times 100$$

- Example if you get 20 points your score would be 20/40 x 100 = 50% and your points for the category would be 50% x 15 = 7.5 points out of the 15 possible points

Improvement Activities in Detail

MIPS: Improvement Activities

Expanded Practice Access: 5 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 alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or
    - Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management
- Medium Weight – 10 Points
  - **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
  - **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

MIPS: Improvement Activities

Population Management: 20 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
- Medium weight – 10 Points
  - Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following:
    - Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups;
    - Integrate a pharmacist into the care team; and/or
    - Conduct periodic, structured medication reviews
  - Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome)

MIPS: Improvement Activities

Care Coordination: 17 Activities

- High weight – 20 Points
  - Participation in the CMS Transforming Clinical Practice Initiative
- Medium weight – 10 Points
  - 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

MIPS: Improvement Activities

Beneficiary Engagement: 23 Activities

- High weight – 20 Points
  - Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan
- Medium weight – 10 Points
  - Use evidence-based decision aids to support shared decision making
  - Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms

MIPS: Improvement Activities

Patient Safety & Practice Assessment: 30 Activities

- High weight – 20 Points
  - Clinicians would attest that 75 percent of time they reviewed and consulted a 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 standardized treatment protocols to manage workflow in the team to meet patient needs
  - Use of QCDR data, for ongoing practice assessment and improvements in patient safety
  - Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of the Surgical Risk Calculator

MIPS: Improvement Activities

Achieving Health Equity: 6 Activities

- High weight – 20 Points
  - Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. Timely is defined as 10 business days
- Medium weight – 10 Points
  - Participation in a QCDR, demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status

MIPS: Improvement Activities

Emergency Response & Preparedness: 2 Activities

- High weight – 20 Points
  - Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater
- Medium weight – 10 points
  - 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

MIPS: Improvement Activities

Behavioral & Mental Health: 9 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

MIPS: Improvement Activities

- **How to get the highest score**
  - Remember 40 points is full score
  - 4 medium weighted activities (4 x 10 points)
  - 2 medium (2 x 10) and 1 high weighted (1 x 20) activity
  - 2 high weighted (2 x 20 points) activities
- If you are in a small practice $\leq$ 15 providers you get double points for each activity
  - 2 medium weighted activities
  - 1 high weighted activity

MIPS: Improvement Activities

- Don't forget the ACI bonus for using CEHRT to complete improvement activities
- For example:
  - If you perform the "provide 24/7 access" improvement activity and you use your CEHRT's secure messaging functionality to provide 24/7 access for advice about urgent care by sending or responding to secure messages outside business hours this would qualify you for the 10% CEHRT improvement activities bonus
  - This bonus accrues to your ACI score not your improvement activities score

MIPS: Improvement Activities

- Document your improvement activities and maintain documentation for 6 years
  - To make sure you are ready for a future audit
  - Maintain documentation that shows you performed the improvement activities that you are claiming credit for
    - For 24/7 access: a patient encounter / medical claim indicating the patient was seen outside normal business hours

Detailed look

Advancing Care Information

MIPS: Advancing Care Information

- Replaces Medicare Meaningful Use
- Contributes 25% to your final score
- Clinicians must use certified EHR technology to report
- Category score is made up of a base score, a performance score, and a possible bonus score

25 % of final score

MIPS: Advancing Care Information

Two measure sets for reporting in 2018

- **2018 Advancing Care Information Transition Objectives and Measures**
  - Adopted from Modified stage 2
- **Advancing Care Information Objectives and Measures**
  - Adopted from Stage 3
  - Bonus of 10% if you report exclusively using the Advancing Care Information Objectives and Measures

MIPS: Advancing Care Information

- The set of measures that you can report depends on whether you have 2014 or 2015 edition certified EHR technology

Advancing Care Information Objectives and Measures

- If you have EHR technology certified to the **2015 edition**
- If you have a combination of technologies from 2014 and 2015 that support these measures

2018 Advancing Care Information Transition Objectives and Measures

- If you have technology certified to the **2015 edition**
- If you have technology certified to the **2014 edition**
- If you have a combination of technologies from 2014 and 2015 that support these measures

MIPS: Advancing Care Information

Calculating your ACI Score

Base Score 0% or 50%
- Report 4 base score measures form the transition set or 5 base measures from the ACI measures set

\+ **Performance Score** 0% - 90%
- Report up to 7 performance score measures from the transition set or up to 9 measures from the ACI set

\+ **Bonus Score** Up to 25%
- 5% for additional registry beyond the one identified for the performance score measure
  10% for using CEHRT for improvement activity
  10% for using only Advancing Care Information Objectives and Measures

= **ACI Score 0% - 100%**
- Your ACI score is capped at 100%

MIPS: Advancing Care Information

Different Levels of ACI Participation

Base score and Performance score

- Base score represents a mandatory core level of participation
- Performance score involves a second level of participation where you are rewarded for your performance rate

MIPS: Advancing Care Information

Base Score

- You must achieve full marks for the ACI base score which is worth 50% of the maximum ACI score
  - To do this you must report 4 or 5 base measures depending on the measure set you use
  - Base score is all or nothing:
    - You must report all the required measures to earn the full base score (50%)
    - If you fall short even on just 1 measure you will score 0% for both the base score and the overall ACI score

MIPS: Advancing Care Information

Base Score

- You must report a Yes / No for the security risk analysis measure
- You must report the numerator and denominator for the other base measures
  - You need a numerator of **at least 1** to successfully report the measure
  - For the base score you don't get any extra points if your numerator is greater than 1

MIPS: Advancing Care Information Base Score

Advancing Care Information Measures Base Score

1. Security Risk Analysis
2. e-Prescribing
3. Provide Patient Access
4. Send a summary of care
5. Request / Accept a summary of care

2018 Advancing Care Information Transition Measures Base Score

1. Security Risk Analysis
2. e-Prescribing
3. Provide Patient Access
4. Health Information Exchange

- Failure to meet reporting requirements will result in a base score of zero, and an advancing care information category performance score of zero

MIPS: Advancing Care Information

Performance Score

- You are eligible for the performance score only if you achieved the base score
- Performance score accounts for up to 90% of your total ACI score
- Report either 7 or 9 performance score measures depending on which measure set you use
  - The transition measure set contains 7 performance score measures
    - 2 mandatory and 5 optional
  - The ACI measure set contains 9 performance score measures
    - 3 mandatory and 6 optional

MIPS: Advancing Care Information Performance Score

Advancing Care Information Objectives and Measures Performance Score	
Objective	**Measure**
1. Patient Electronic Access	Provide Patient Access *
2. Patient Electronic Access	Patient-Specific Education
3. Coordination of care through patient engagement	View, Download, and Transmit
4. Coordination of care through patient engagement	Secure Messaging
5. Coordination of care through patient engagement	Patient-generate health data
6. Health Information Exchange	Send a Summary of Care *
7. Health Information Exchange	Request/Accept a Summary of Care *
8. Health Information Exchange	Clinical Information Reconciliation
9. Public Health and Clinical Data Registry Reporting	One of the Public Health and Clinical Data Registry Reporting Measures

2018 ACI Transition Objectives and Measures Performance Score	
Objective	**Measure**
1. Patient Electronic Access	Provide Patient Access *
2. Patient Electronic Access	View, Download, and Transmit
3. Patient-Specific Education	Patient-Specific Education
4. Secure Messaging	Secure Messaging
5. Health Information Exchange	Health Information Exchange *
6. Medication Reconciliation	Medication Reconciliation
7. Public Health Reporting	One of the Public Health Reporting Measures

MIPS: Advancing Care Information

Performance Score

- Your score for each performance measure will depend on your actual performance rate
  - Most measures are assigned a score of 0-10% using decile based scoring
  - Example you submit a num / den of 85/100 your perf. rate is 85 and your score would be 9% for that objective

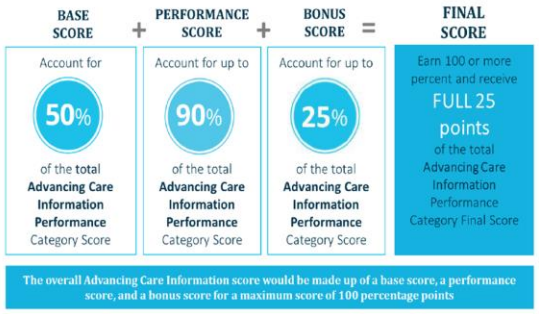
Performance Rate (Numerator / Denominator)	Your Score
0	0%
1-10	1%
11-20	2%
21-30	3%
31-40	4%
41-50	5%
51-60	6%
61-70	7%
71-80	8%
81-90	9%
91-100	10%

MIPS: Advancing Care Information Bonus Score

- **5% Bonus** for reporting on one or more of the following public health agencies or clinical data registries not reported for the performance score:
  - Immunization Registry Reporting
  - Syndromic Surveillance Reporting
  - Electronic Case Reporting
  - Public Health Registry Reporting
  - Clinical Data Registry Reporting

- **10% Bonus** for:
  - Using CEHRT to report certain Improvement Activities
- **10% Bonus** for:
  - Report exclusively from the Advancing Care Information Measures

MIPS: Advancing Care Information Category Score



MIPS: Advancing Care Information

Several routes to a High ACI Score

- Your ACI score is capped at 100% but a total of 165 percentage points are available
  - 50% from base score
  - 90% from the performance score
  - 5% additional registry bonus
  - 10% CEHRT for improvement activities bonus score
  - 10% reporting using Advancing Care Objectives bonus score
- CMS designed ACI this way to allow you more than 1 way to achieve a high score

MIPS: Advancing Care Information

Example Scoring

- You met the requirements for:
  - Base score 50%
  - Extra Registry bonus 5%
  - CEHRT for improvement bonus 10%
  - In this example you now have an ACI score of 65%
    - You only need to accrue a performance score of 35% (from the 90% available) to get a perfect score for ACI
    - You could then either submit all the performance measures and if you do OK not even great on them you will have a high ACI score
    - You might instead choose to focus your efforts on the performance measures where you are most likely to be successful

Advancing Care Information: **Prevention of Information Blocking Attestation**

Prevention of Information Blocking: Making sure EHR Information is Shared

- To receive a score in the ACI category MIPS eligible clinicians are required to **attest to three statements** to show that they have not knowingly and willfully limited or restricted the compatibility or interoperability of their CEHRT

1. A MIPS eligible clinician must attest that they did not did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of CEHRT

Prevention of Information Blocking: Making sure EHR Information is Shared

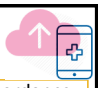
2. A MIPS eligible clinician must attest that they implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the CEHRT was, at all relevant times
   - Connected in accordance with applicable law
   - Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR Part 170
   - Implemented in a manner that allowed for timely access by patients to their electronic health information (including the ability to view, download, and transmit this information)
   - Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate CEHRT and health IT vendors

Prevention of Information Blocking: Making sure EHR Information is Shared

3. A MIPS eligible clinician must attest that they responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor

Advancing Care Information: **Base Objectives in Detail**

Protect Electronic Health Information



ACI - Base Objective

- 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 CFR164.312(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
- Objective is the same for both ACI Objectives and Measures and the 2018 ACI Transition Objectives and Measures

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

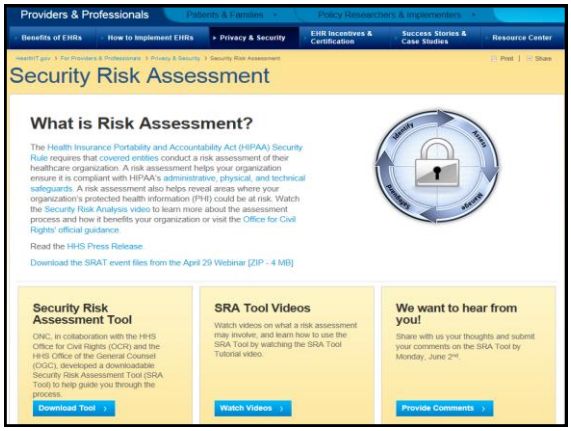
- HIPAA protects the privacy of individually identifiable health information, called **protected health information (PHI)**
- Security Rule protects a subset of information covered by the Privacy Rule, which is all individually identifiable health information a covered entity creates, receives, maintains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

Annual Security Risk Assessment Cycle

Protect electronic health information

Where to get more help:

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



Electronic Prescribing

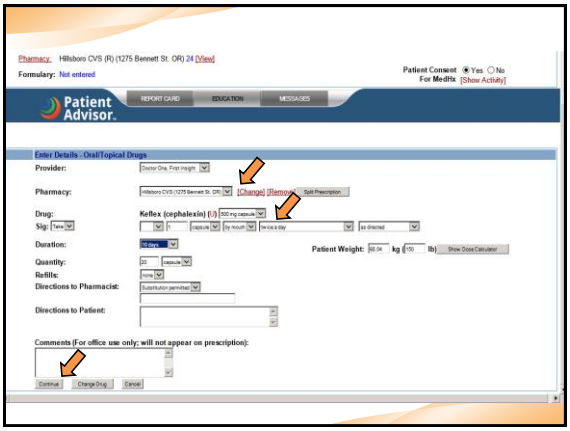
ACI - Base Objective

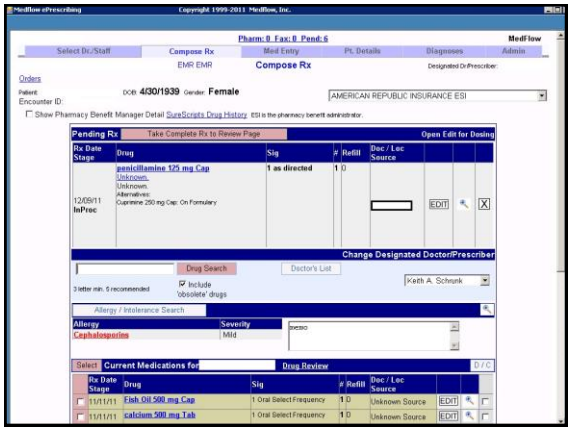
- At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology
  - May report a null value if write fewer than 100 permissible prescriptions for the performance period
- Objective is the same for both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures

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

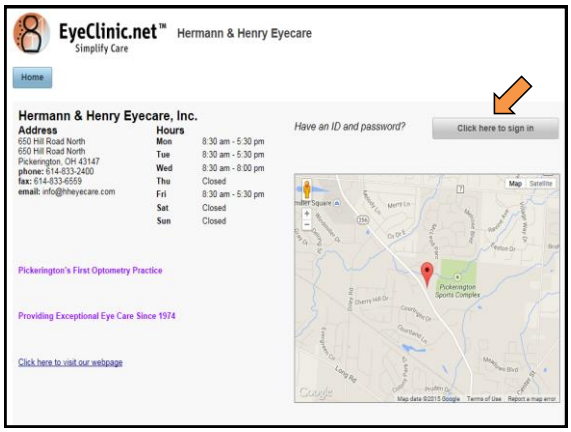


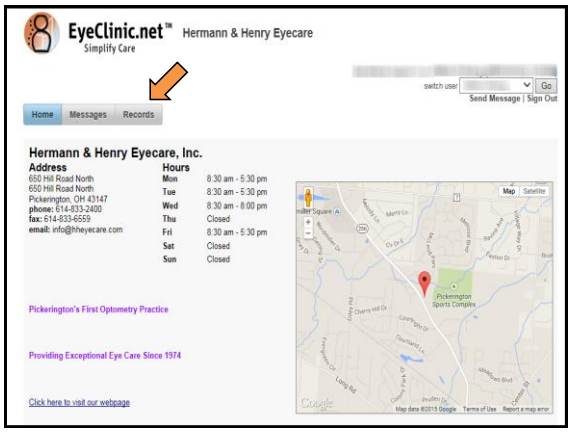


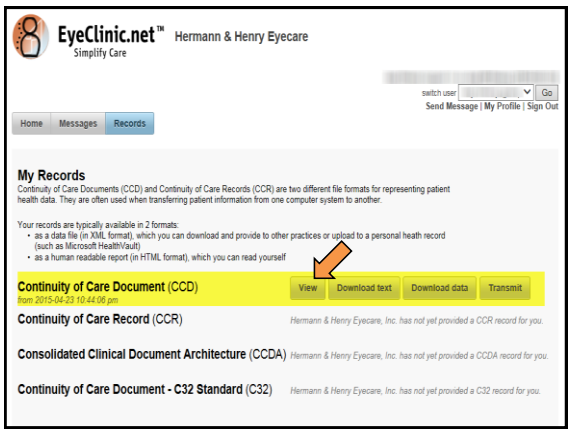
Patient Electronic Access

ACI – Base and Performance Objective

- **Provide 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 Programing Interface (API) in the MIPS eligible clinician's certified EHR technology
- Part (2) does not apply to clinicians using the 2018 ACI Transition Objectives and Measures
- Also a performance score objective so numerator and denominator are important
  - Performance Score Weight: Up to 10%
  - Weight for 2018 Transition Objectives & Measures: Up to 20%







Patient 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

Health Information Exchange

ACI – Base and Performance Objective

- **Send a Summary of Care**: 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

- Objective is the same for both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures
- Also a performance score objective so numerator and denominator are important under both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures

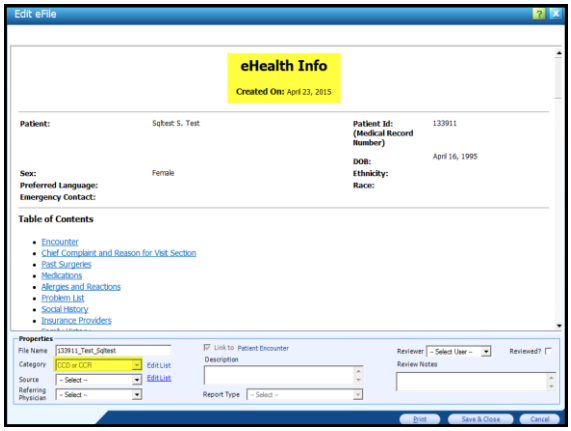
- Performance Score Weight: Up to 10%
  - Weight for 2018 Transition Objectives & Measures: Up to 20%

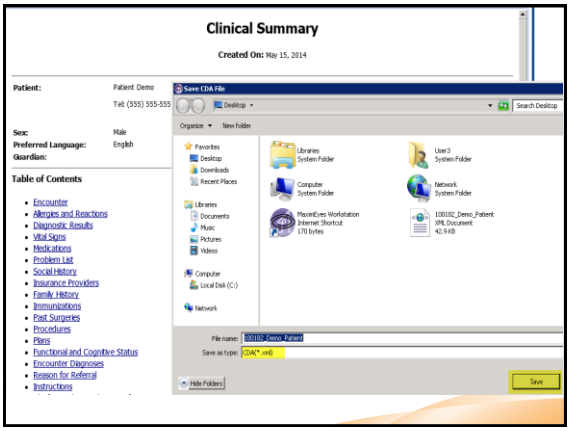
Summary of Care Record for Transitions of Care

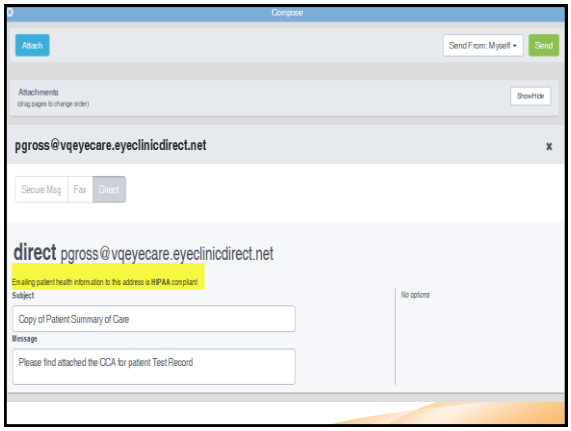
Clinical Significance?

- 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







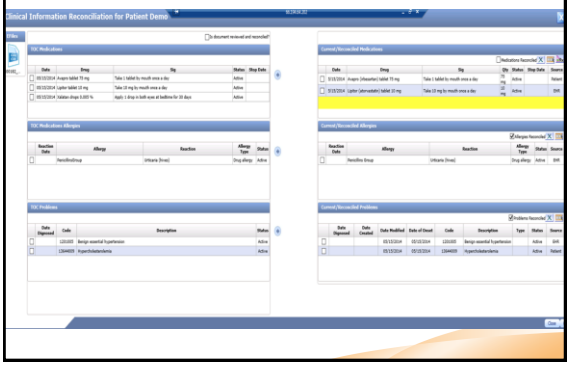
Health Information Exchange

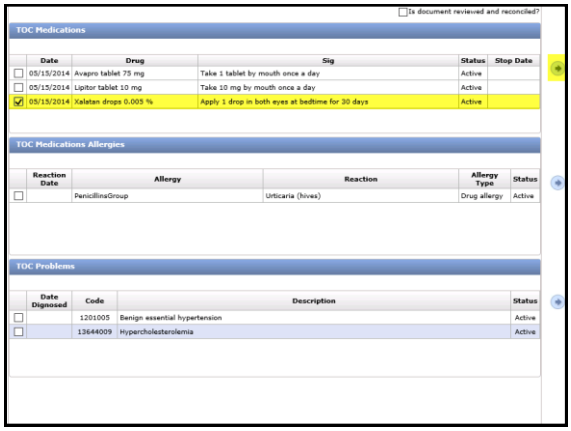
ACI – Base and Performance Objective

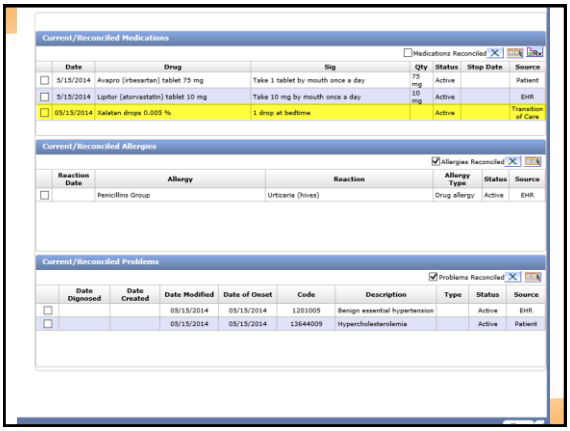
- **Request/Accept Summary of Care:** For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician receives or retrieves and incorporates into the patient's record an electronic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

- Does not apply to clinicians using 2018 ACI Transition Objectives and Measures for base or performance
- Also a performance score objective so numerator and denominator are important if using ACI Objectives and Measures
- Performance Score Weight: Up to 10%

Request/Accept Summary of Care







Advancing Care Information: **Performance Objectives in Detail**

Patient Electronic Access

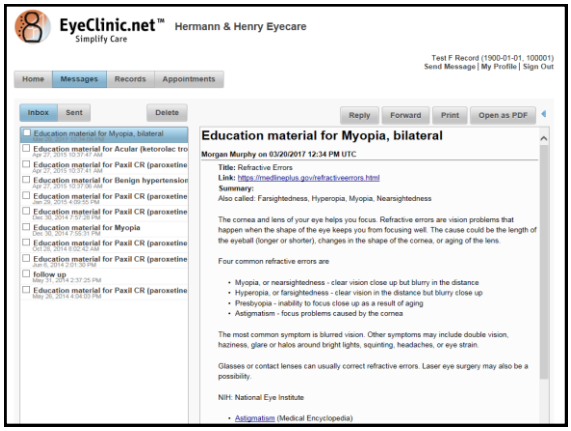
ACI - Performance Objective

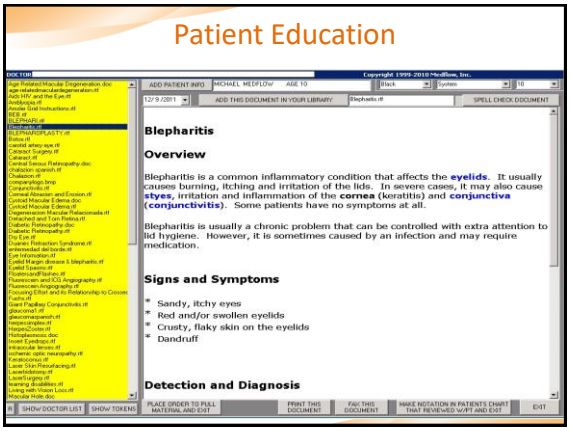
- **Patient-Specific Education:** The MIPS eligible clinician must use clinically relevant information from certified EHR technology to identify patient-specific educational resources and provide electronic access to those materials to at least one unique patient seen by the MIPS eligible clinician
- Performance Score Weight: Up to 10%
- Objective applies to both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures
  - The electronic access does not apply to the 2018 Transition Objectives and Measures

Patient specific education resources

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

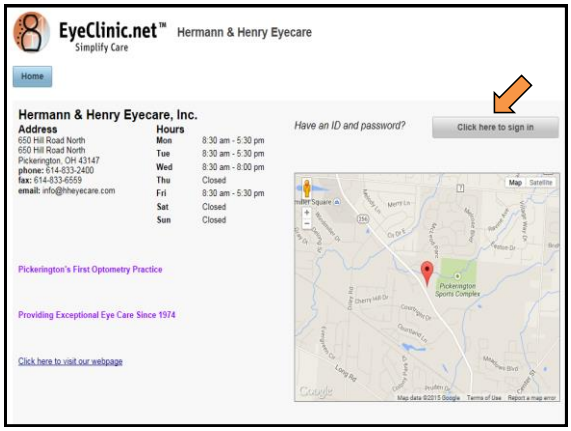


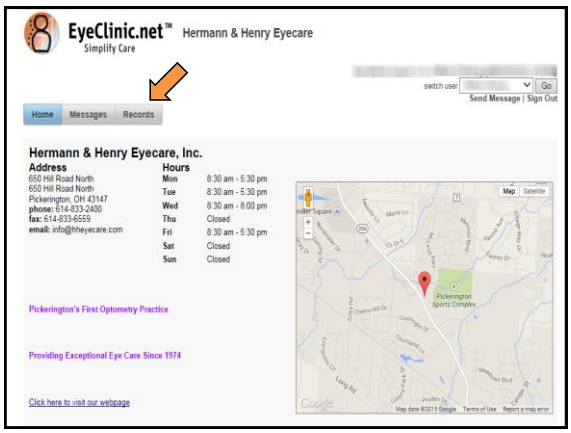


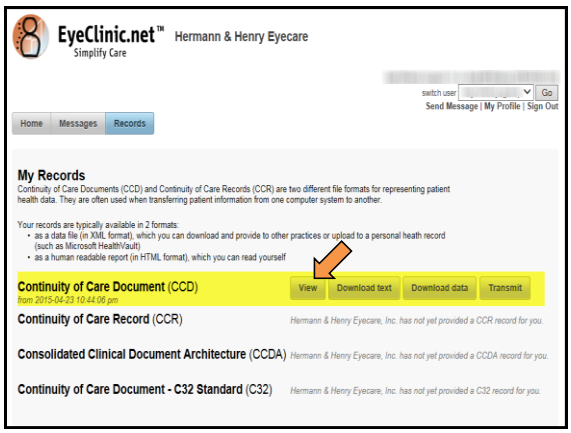
Coordination of Care Through Patient Engagement

ACI - Performance Objective

- **View Download and Transmit (VDT):** During the performance period, at least one unique patient (or patient-authorized representatives) 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
- Performance Score Weight: Up to 10%
- Only part (1) above applies to both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures





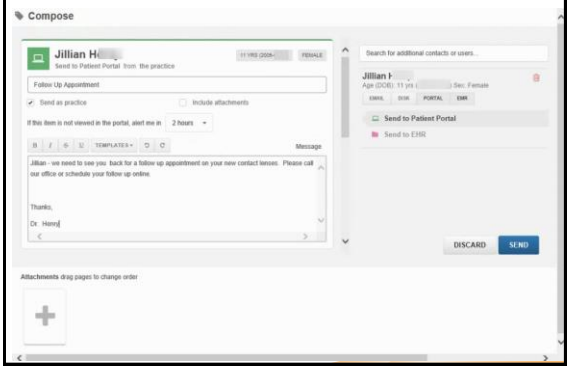


Coordination of Care Through Patient Engagement

ACI - Performance Objective

- **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)
- Performance Score Weight: Up to 10%
- Objective is the same for both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures

Secure Messaging



Coordination of Care Through Patient Engagement

ACI - Performance Objective

- **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
- Performance Score Weight: Up to 10%
- Objective does not apply to clinicians using the 2018 ACI Transition Objectives and Measures

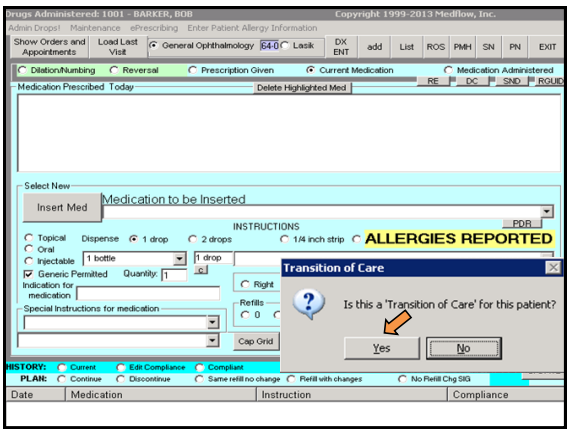
Information From Patient or Non-Clinical Setting

- 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.

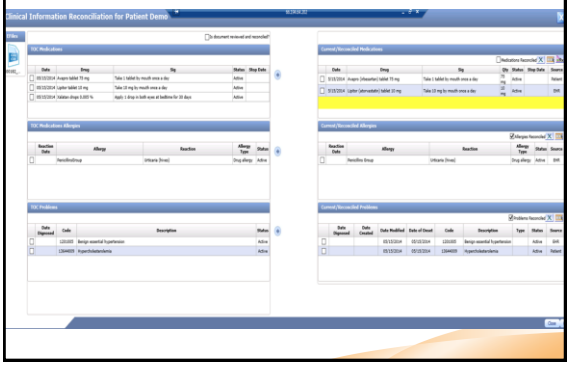
Health Information Reconciliation

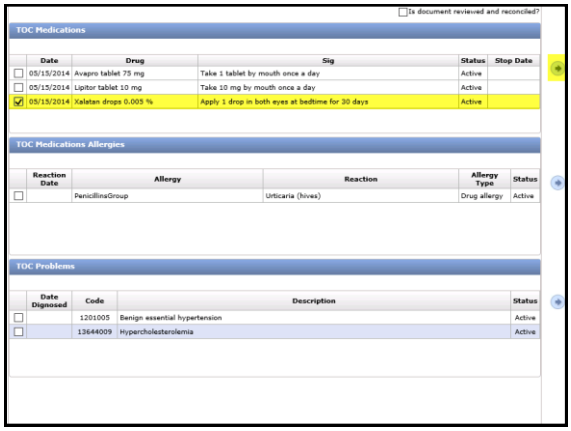
ACI - Performance Objective

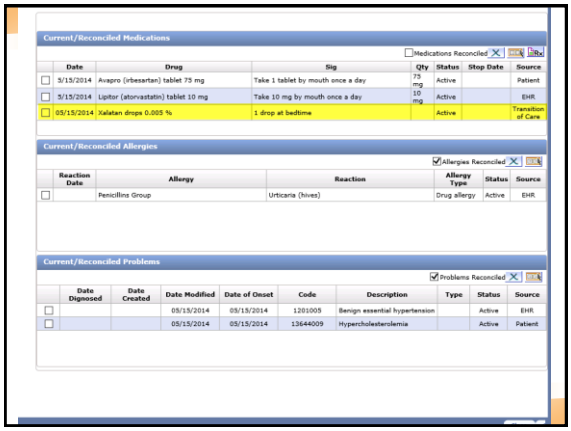
- **Clinical Information Reconciliation:** For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician performs clinical information reconciliation
  - The MIPS eligible clinician 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
- Performance Score Weight: Up to 10%
- Objective applies to both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures
  - Parts (2) and (3) do not apply to the 2018 Transition Objectives and Measures



Clinical Information Reconciliation







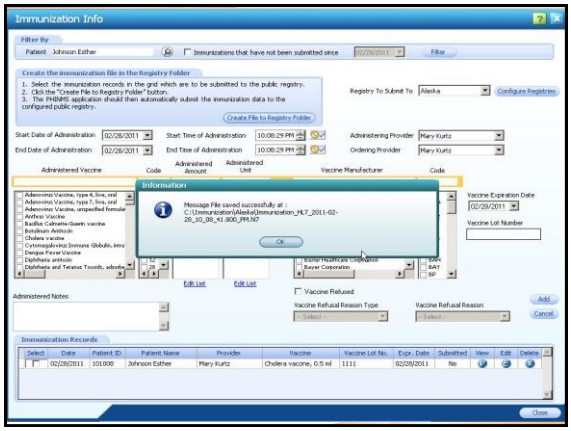
Public Health and Clinical Data Registry Reporting

ACI - Performance Objective

- **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)
- Performance Score Weight: 0 or 10%
- Objective applies to both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures

Public Health Reporting: Active Engagement

- 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 produciton data to PHA or CDR



Public Health and Clinical Data Registry Reporting

ACI - Performance Objective

- **Syndromic Surveillance Reporting:** The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from a urgent care ambulatory setting where the jurisdiction accepts syndromic data from such settings and the standards are clearly defined. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries
- Performance Score Weight: 0 or 5% Bonus
- Objective is the same for both ACI Objectives and Measures and 2018 ACI Transition Objectives and Measures

Public Health and Clinical Data Registry Reporting

ACI - Performance Objective

- **Electronic Case Reporting:** The MIPS eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries
- Performance Score Weight: 0 or 5% Bonus
- Objective does not apply to clinicians using the 2018 ACI Transition Objectives and Measures

Public Health and Clinical Data Registry Reporting

ACI - Performance Objective

- **Public Health Registry Reporting:** The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries
- Performance Score Weight: 0 or 5% Bonus
- Objective does not apply to clinicians using the 2018 ACI Transition Objectives and Measures

Public Health and Clinical Data Registry Reporting

ACI - Performance Objective

- **Clinical Data Registry Reporting:** The MIPS eligible clinician is in active engagement to submit data to a clinical data registry. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries
- Performance Score Weight: 0 or 5% Bonus
- Objective does not apply to clinicians using the 2018 ACI Transition Objectives and Measures

Public Health Reporting

ACI - Performance Objective

- **Specialized Registry Reporting:** The MIPS eligible clinician is in active engagement to submit data to specialized registry. Earn a 5% bonus in the advancing care information performance category score for submitting to one or more public health or clinical data registries
- Performance Score Weight: 0 or 5% Bonus
- Objective only applies to clinicians using the 2018 ACI Transition Objectives and Measures

MIPS: Advancing Care Information Category Score

Example of Base Scoring:

Measure	Result
Security Risk Analysis	Yes
e-Prescribing	30/150
Provide Patient Access*	250/500
Send Summary of Care*	100/150
Request/Accept Summary of Care*	25/50

Fulfilled base score = 50%

* Also a performance objective

MIPS: Advancing Care Information Category Score

Example of Performance Scoring:

Measure	Num/ Den	Perf Rate	% Score
Provide Patient Access	250/500	50	5%
Patient-Specific Education	15/500	3	1%
View, Download, or Transmit	300/500	60	6%
Send Summary of Care	140/150	93	9%
Request/Accept Summary of Care	25/50	50	5%
Immunization Registry Reporting	No		0%
Total Performance			26%

MIPS: Advancing Care Information Category Score

Example of Bonus Scoring:

Measure	Result	Score
Specialized Registry Reporting Bonus	Yes	5%
Improvement Activities Bonus for Providing 24/7 access to eligible clinicians via real time access to patient's medical record in EHR	Yes	10%
Total bonus score		15%

MIPS: Advancing Care Information Category Score

Example of Scoring Total for Advancing Care Information:

Base Score	50%
Performance Score	26%
Bonus Score	15%
Total Score	**91%**
Final Score	**91% x 25 = 22.75 points out of 25 total**

Calculating the Final Score Under MIPS

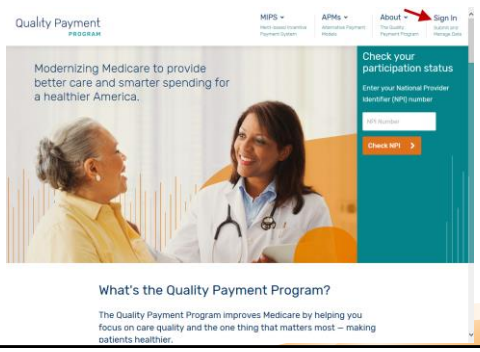
Final Score =

Quality performance category score x actual Quality performance category weight + Cost performance category score x actual Cost performance category weight + Improvement Activities performance category score x actual Improvement Activities performance category weight + Advancing Care Information performance category score x actual Advancing Care Information performance category weight x 100

MIPS Data Submission Methods

	Individual	Group
Quality	✓ QCDR *(Qualified Clinical Data Registry)* ✓ Qualified Registry ✓ EHR ✓ Claims	✓ QCDR *(Qualified Clinical Data Registry)* ✓ Qualified Registry ✓ EHR ✓ Administrative Claims ✓ CMS Web Interface (groups of 25 or more) ✓ CAHPS for MIPS Survey
Improvement Activities	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ CMS Web Interface (groups of 25 or more)
Advancing Care Information	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor

MIPS Data Submission



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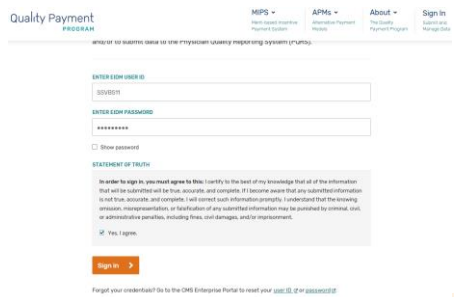

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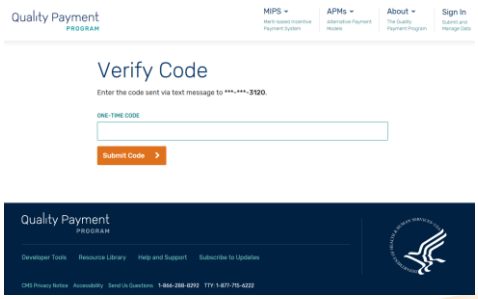

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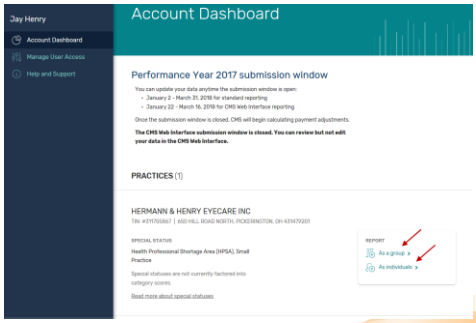

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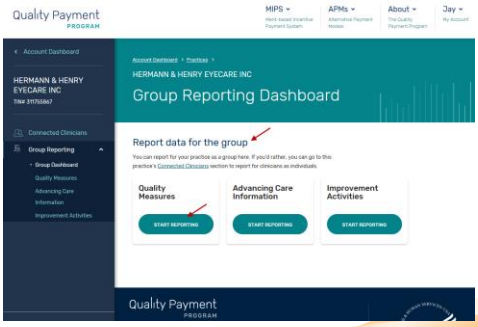

MIPS Data Submission

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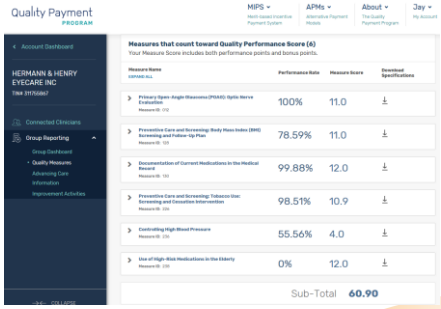

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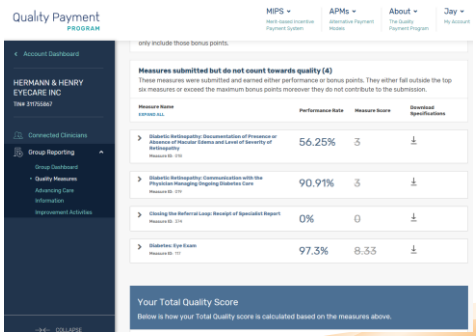

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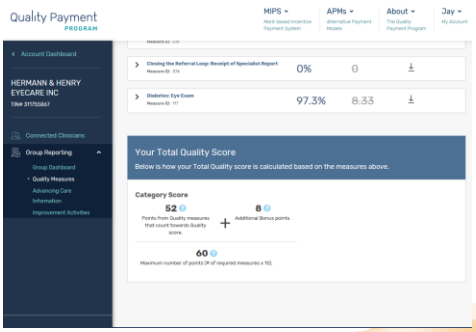

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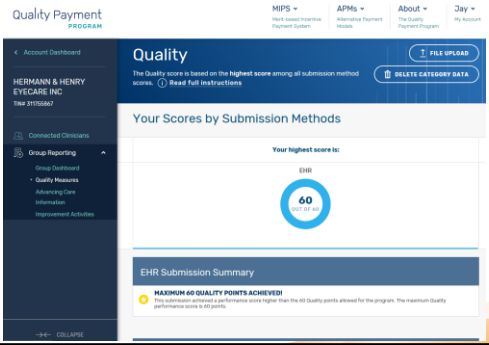

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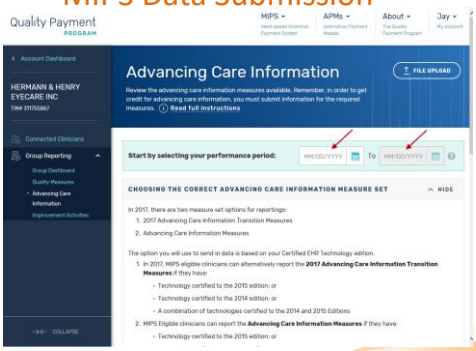

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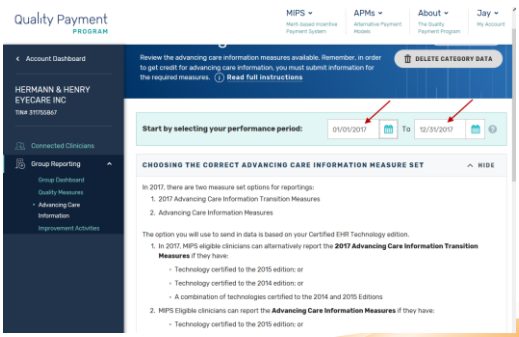

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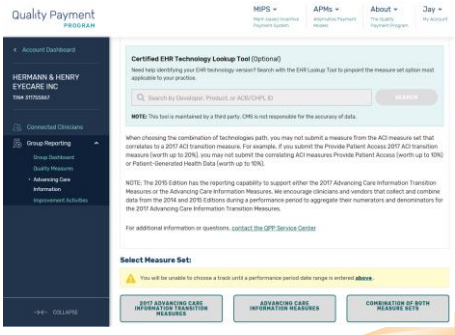

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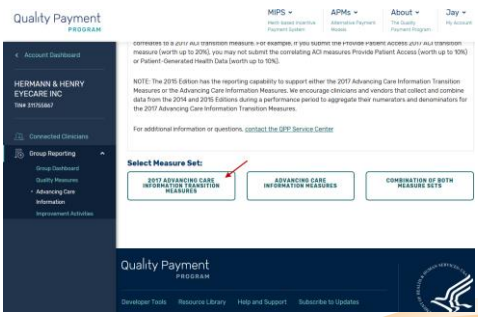

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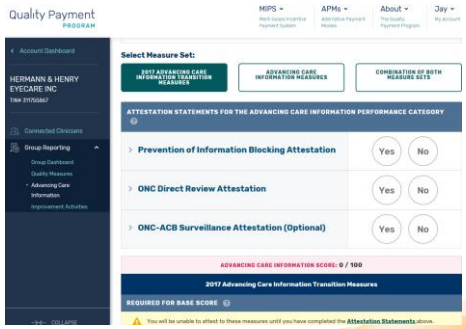

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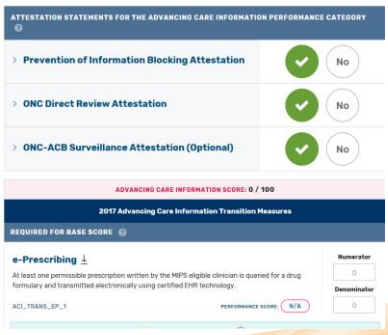

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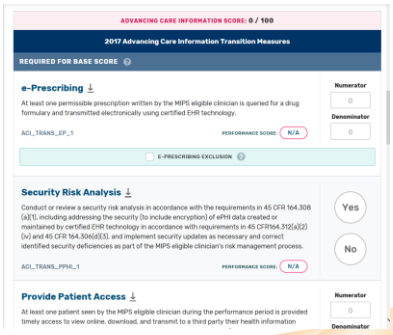

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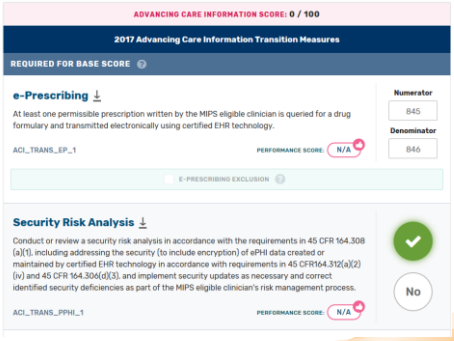

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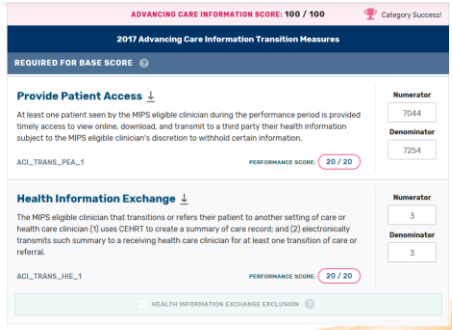

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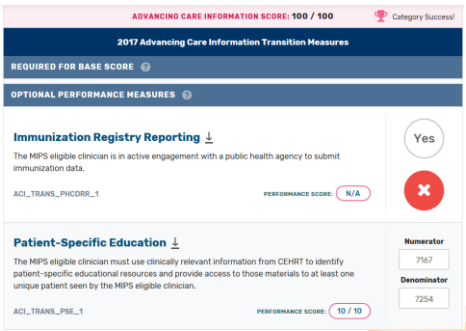

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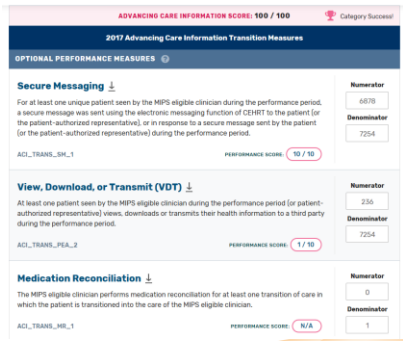

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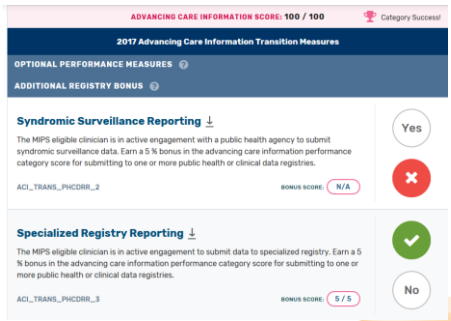

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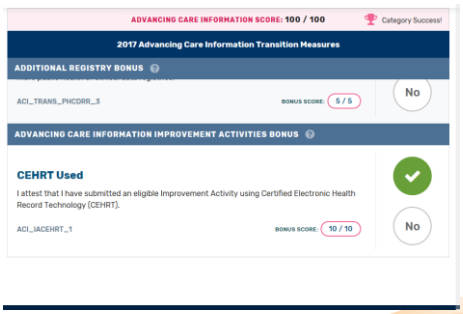

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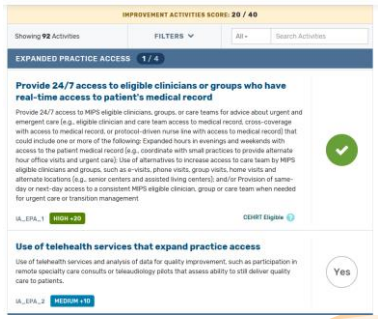

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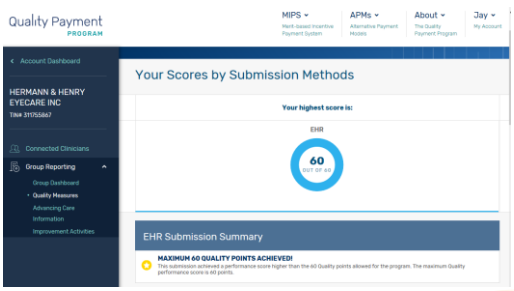

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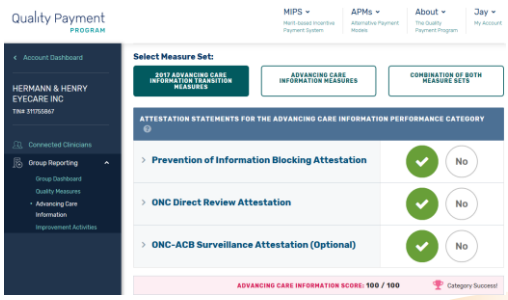

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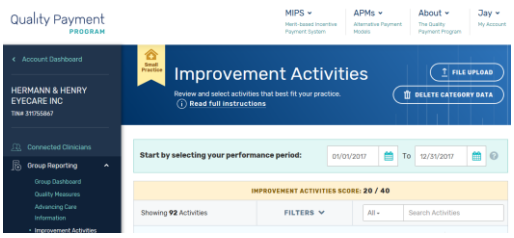

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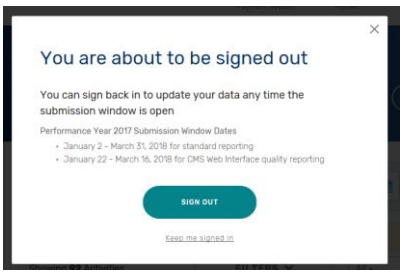
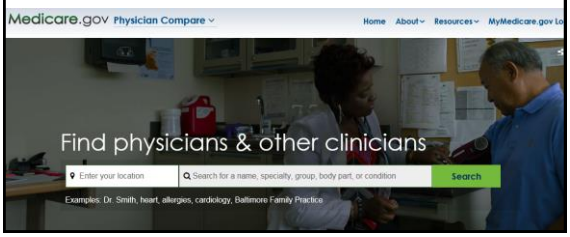


MIPS: Public Reporting

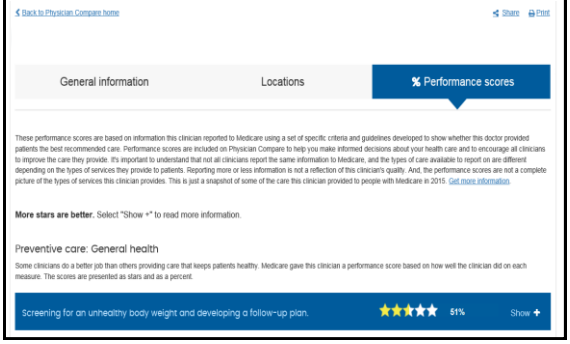
- Your MIPS final score is available for public reporting
- All MIPS data are available for public reporting on Physician Compare Website

MIPS Score

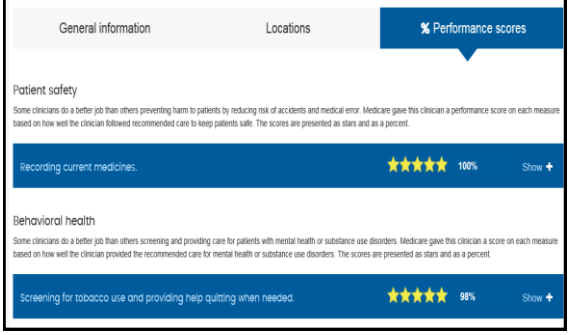
- MIPS scoring will be made public at: https://www.medicare.gov/physiciancompare



MIPS Score



MIPS Score



MIPS Score

MACRA / MIPS Audits

MIPS Audits

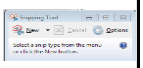
- CMS will conduct data validation and audits to ensure that the QPP operates on accurate and useful data
- If selected for data validation or an audit providers will have 45 calendar days to complete the data sharing as requested
- In accordance with the False Claims Act, you should keep documentation up to **6 years**

MIPS Audits

- You will always use your CEHRT MIPS report for your primary documentation during an audit
- CMS also states that this report will need to include:
  - The time period the report covers (reporting period)
  - The clinician identification (NPI / Name)
  - Evidence to support that the report was generated by the CEHRT (take a screen shot of the report before it is printed)
- You should also acquire screen shots of certain objectives and activities to help validate that you accomplished them as required

How to get Screen Shots

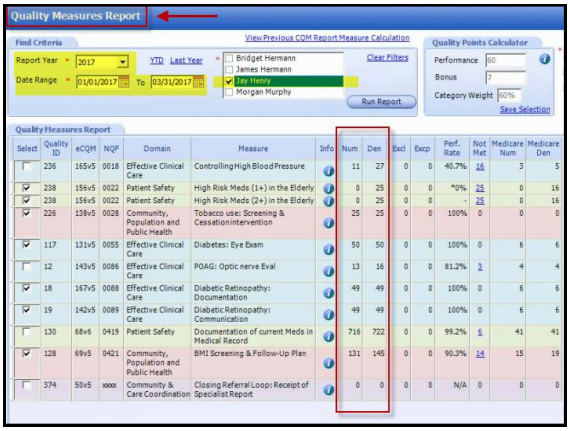
- Window's free – "Snipping Tool"
  - Start, Accessories, and find Snipping Tool



- **PrtScn** on keyboard which copies to clipboard, holding area, and then past in to Word
- Techsmith's advanced tool called "Snagit"

MIPS Audits

- **Quality category**
  - You may be audited to validate that you submitted all applicable measures and encounters
    - Especially if you submit fewer than 6 measures
    - Also if you do not submit the required outcome measure or other high priority measure
  - An audit may also look to be certain that proper age ranges were used in calculating numerators and denominators



MIPS Audits

- **Advancing Care Information category**
  - You should retain documentation to support submissions for each objective
    - EHR Report
    - Screenshots

Electronic Prescribing

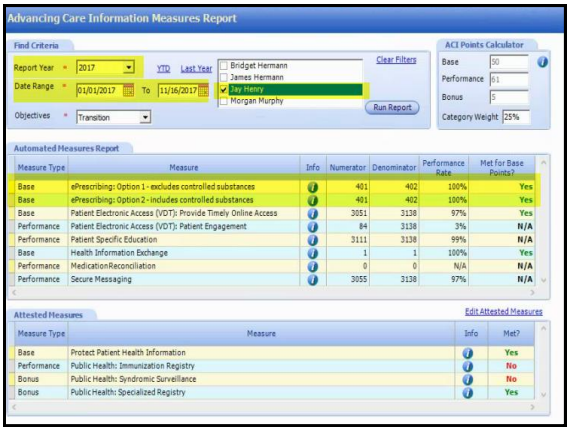
ACI - Base Objective

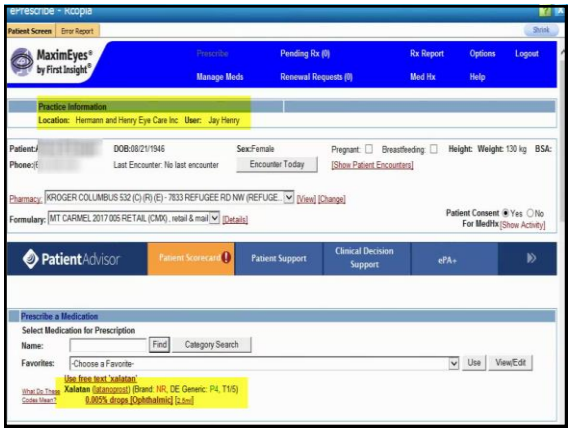
- At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology

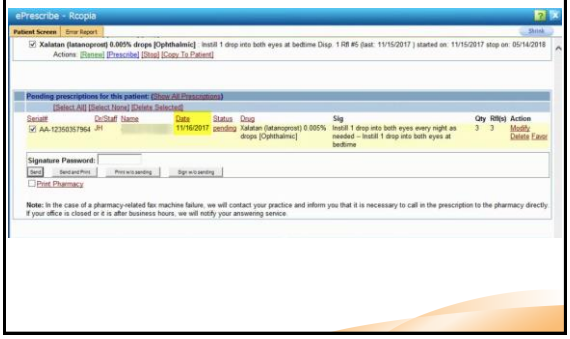
Suggested Documentation

ACI - Base Objective

- Report from the EHR system showing numerator, denominator, and percentage are valid for this measure
- You should have a **screen shot** showing eRx for a patient for you as provider in the date range attesting for

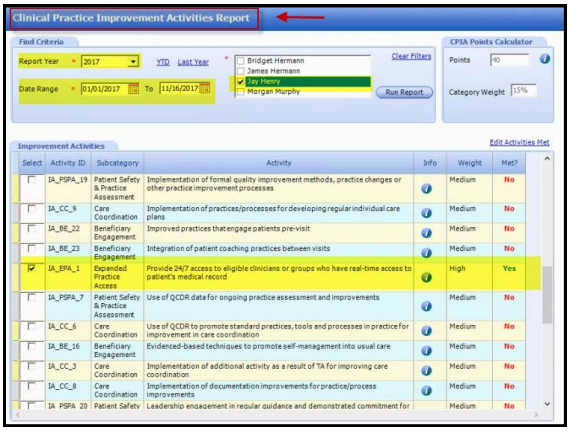






MIPS Audits

- **Improvement Activities category**
  - You should retain documentation that validates your activities
  - Documentation should demonstrate consistent and meaningful engagement within the period for which you attested



Provide 24/7 access

- 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 alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or
  - Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management

Suggested Documentation

- Patient record from EHR
  - With date and timestamp indicating services provided outside of normal business hours for that clinician
- Patient encounter / claim
  - Patient encounter / claim indicating patient was seen or services provided outside of normal business hours

MIPS Audits

- **Cost category**
  - Since the cost data is captured based on your Medicare claims data your claims could be audited for accuracy

YOU HAVE BEEN SELECTED!

MAY THE ODDS BE EVER IN YOUR FAVOR

Questions?

Jay W. Henry, O.D., M.S.