On Track for MACRA –
The Provider’s Guide to QPP

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Overview

CMS Programs
MEDICARE

- Stage 1
- Stage 2
- Modified Stage 2

MEDICAID

- Stage 1
- Stage 2
- Modified Stage 2
- Stage 3

Quality Payment Program

MIPS ▼ Merit-based Incentive Payment System

APMs ▼ Alternative Payment Models
EHR Incentive/Meaningful Use – Medicare/Medicaid

Meaningful Use for Eligible Medicare Professionals
• Applicable from 2011 through reporting year 2016
• First-time EPs who have not demonstrated meaningful use successfully prior to 2017 have until October 1, 2017 to attest or to apply for hardship exception
• Replaced by Quality Payment Program ACI, effective reporting year 2017

Meaningful Use for Eligible Medicaid Professionals
• Applicable from 2011 and continuing through 2021
• Last year for a clinician to register as a new participant was 2016
• ECs may also be eligible for MIPS
• Please refer to your state agency for appropriate details at:
Quality Payment Program

QPP (Quality Payment Program)
- [https://www.qpp.cms.gov](https://www.qpp.cms.gov)
- Replaces EHR Incentive/Meaningful Use for Medicare providers
- MACRA umbrella includes two performance-based tracks: **MIPS** and **AAPM**
  which replace traditional Medicare Fee For Service

MIPS (Merit-based Incentive Payment System)
- Combines 3 legacy programs + adds one new performance category
  **Note:** For 2017 the Cost category is not applicable.
- A performance MIPS Score is calculated for the EC from all categories

AAPM (Advanced Alternative Payment Model)
- Providers may register to participate and CMS must approve you
- Incentive payments based on innovative payment models

EHR Incentive Program/meaningful Use (MU)
- Ended in 2016 for Medicare providers
- Continues through 2021 for Medicaid providers
- Check with your state agency for specifics
MIPS Eligibility/Participation for Clinicians
Provider Eligibility*

MIPS – Eligible (Medicare)
- Physicians, Physician Assistants, Nurse Practitioners
- Clinical Nurse Specialists, Certified Registered Nurse Anesthetists
- Meet or exceed the Med-B low volume threshold^ 

Ineligible to Participate in MIPS
- Physical/Occupational Therapists, Clinical Social Workers, Certified Midwives
- Clinicians who enroll with Medicare for the first time in 2017
- Clinicians who fail to meet one or both of the low-volume threshold^ criterion
- Clinicians who participate in an Advanced APM

^Low-volume threshold (Medicare): Clinicians who bill $30,000 or more Medicare B allowed charges and have provided care for 100 or more Part B-enrolled beneficiaries.

Meaningful Use – Eligible (Medicaid)
- Requirements unchanged from previous years
- Refer to your state agency for specific requirements relevant to your practice
- 2016 was the last year a Clinician could register to participate with MU program
- Eligible professionals may also be eligible for MIPS if applicable

*See Appendix B – “QPP Getting Started Checklist”
MIPS Participation

https://qpp.cms.gov/participation-lookup
https://qpp.cms.gov/mips/individual-or-group-participation

Eligible Clinician’s NPI
MIPS Participation (cont’d)

Individual

• A clinician whose individual NPI is tied to a single Tax Id Number (TIN)
• Data will be submitted individually for each MIPS category
• Payment adjustment in 2019 is based solely on the individual’s performance/MIPS score

Group

• A Group exists when 2 or more clinicians (NPIs) have reassigned their Medicare billing rights/benefits to a single Tax Id Number (TIN)
• Payment adjustment in 2019 is based upon the performance of all ECs in the group (even if the individual is not otherwise eligible individually)

• See Appendix C – Group Reporting Payment Adjustments
• For more details about Groups, please visit: https://qpp.cms.gov/mips/individual-or-group-participation/about-group-registration
MIPS Participation Status (Example)

- EC may be eligible individually
- EC may be eligible as part of a group but not individually
- EC may be eligible both as an individual & as part of a group

- EC may be part of multiple groups and have different designation with each one
- EC may be totally exempt
EC Special Designations

-- CMS makes special provisions for those providers with special circumstances

Note: For example, these providers get double points under the IA category.

- Small Practice (15 providers or less)
- Rural Health Practice
- Health Professional Shortage Area (HPSA)
“Pick Your Pace” for 2017 – Participation Level

• Payment adjustment in 2019 is based upon your level of participation in 2017

- **No Participation** – negative 4% payment adjustment in 2019
  
  *Note*: An ineligible EC will not receive a negative adjustment.

- **Test/Minimal Participation** – zero payment adjustment in 2019
  
  • Submit some data for at least 1 category for any number of days
  
  • **Base** – all 5 measures required for any quantity of data/number of days
  
  • **Quality/IA** – at least 1 measure for any quantity of data/number of days

- **Partial Participation** – neutral or small positive payment adjustment in 2019
  
  • Submit at least 90 days worth of data (must begin collection by Oct. 2 at latest)
  
  • **Base** – all 5 measures required
  
  • **Quality** – minimum of 6 measures required
  
  • **IA** – 40 points required

- **Full Participation** – up to possible maximum positive 4% payment adjustment in 2019
  
  • Submit a full year of data for all categories
  
  • Same requirements as the **Partial Participation** above
MIPS Reporting
MIPS Overview

- [https://qpp.cms.gov/mips/overview](https://qpp.cms.gov/mips/overview)
- Consists of 3 existing quality reporting programs combined with 1 new category
  - **Quality** – replaces former PQRS (Physician Quality Reporting System)
  - **Improvement Activities (IA)** – new performance category
  - **Advancing Care Information (ACI)** – replaces former MU (Meaningful Use)
  - **Cost** – replaces the Value Based Modifier (n/a for 2017)
- ECs are able to choose which measures are meaningful within their practice in conjunction with the data submission method

<table>
<thead>
<tr>
<th>Quality</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replaces PQRS.</td>
<td>New Category.</td>
<td>Replaces the Medicare EHR Incentive Program also known as Meaningful Use.</td>
</tr>
</tbody>
</table>

### Diagram

- **Cost** is crossed out, indicating it is not included in MIPS for 2017.
Data Submission Methods

- **indicates data submission methods* supported by PrognoCIS**
- **EHR/EHR Vendor** – PrognoCIS will have an API screen that interfaces to CMS
- **Claims** – CMS will extract the data from claims submitted during reporting period
- **Attestation** – CMS will have an API screen on the QPP web site
- Data submission will occur between January 1 and March 31, 2018

<table>
<thead>
<tr>
<th>Category</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>✓ QCDR (Qualified Clinical Data Registry)</td>
<td>✓ QCDR (Qualified Clinical Data Registry)</td>
</tr>
<tr>
<td></td>
<td>✓ Qualified Registry</td>
<td>✓ Qualified Registry</td>
</tr>
<tr>
<td></td>
<td>✓ EHR</td>
<td>✓ EHR</td>
</tr>
<tr>
<td></td>
<td>✓ Claims</td>
<td>✓ Administrative Claims</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ CMS Web Interface (25 or more)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ CAHPS for MIPS Survey</td>
</tr>
<tr>
<td>Advancing Care</td>
<td>✓ Attestation</td>
<td>✓ Attestation</td>
</tr>
<tr>
<td>Information</td>
<td>✓ QCDR</td>
<td>✓ QCDR</td>
</tr>
<tr>
<td></td>
<td>✓ Qualified Registry</td>
<td>✓ Qualified Registry</td>
</tr>
<tr>
<td></td>
<td>✓ EHR Vendor</td>
<td>✓ EHR Vendor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ CMS Web Interface (25 or more)</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>✓ Attestation</td>
<td>✓ Attestation</td>
</tr>
<tr>
<td></td>
<td>✓ QCDR</td>
<td>✓ QCDR</td>
</tr>
<tr>
<td></td>
<td>✓ Qualified Registry</td>
<td>✓ Qualified Registry</td>
</tr>
<tr>
<td></td>
<td>✓ EHR Vendor</td>
<td>✓ EHR Vendor</td>
</tr>
</tbody>
</table>

*The method of reporting determines which measures are applicable for the Quality category.*
The Measures by Category
Quality Measures

Counts for 60% of overall MIPS score
Select measures that best fit your practice

Note: Some measure definitions may change each calendar year as ICD and CPT codes are updated. Some may not yet be supported within PrognoCIS.

Choose up to 6 measures per chosen method of data submission
  • Must include 1 Outcome measure
  • If there is no Outcome measure for your specialty, choose a High priority one

Total of 74 claims-based measures
  • 26 measures carried forward from PQRS
    Note: Current PQRS users do not need to make any changes.
  • 50% or more of Medicare Part B claims must be reported with QDCs

Total of 53 EHR-based measures
  • 22 measures carried forward from MU → CQM
  • 50% or more Medicare Part B patients who meet denominator requirements must be reported

Note: All eCQM Measures require certification; see Appendix D – eCQM Measures.

https://qpp.cms.gov/mips/quality-measures
Selecting *Quality Measures*

1. Filter by *High Priority* status, *Data Submission Method*, and/or *Specialty*
2. Filtered measures will display and can be expanded to read the definition/criteria

*Note: PrognoCIS supports Claim-based and EHR-based submission. All measures reported must be the same data submission type.*
Viewing *Quality Measure* Details

1. At least 1 reported measure must be *Outcome* type
2. If no *Outcome* measure applies, then 1 *High Priority: Yes* must be reported
Improvement Activities Measures (IA)

- Counts for 15% of overall MIPS score
- Select activities that improves the overall clinical practice
- Choose/implement from 2 to 4 activities (report a score of 40 points)
  - 10 points = *Medium* weight activities
  - 20 points = *High* weight activities
- Total of 92 activities in 9 categories
  - By default, IAs do not require data to be collected in EHR (they are Yes/No attestation results rather than numerator/denominator values.) The clinic is responsible, however, for maintaining appropriate documentation for up to 6 years when they attest Yes.
  - The 18 designated ACI-related activities do require data be captured and reported through CEHRT in order to receive the 10 Bonus Points under ACI.

https://qpp.cms.gov/mips/improvement-activities
Selecting Improvement Activities

1. Filter by *Sub-category Name* and/or *Activity Weightage*
2. Filtered activities will display and can be expanded to read the definition/criteria
### ACI Bonus Scoring Improvement Activities – Example

- These 18 Improvement Activities also count towards 10 ACI Bonus points if the data is captured within a CEHRT for at least 1 or more

<table>
<thead>
<tr>
<th>Improvement Activity Performance Category Subcategory</th>
<th>Activity Name</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded Practice Access</td>
<td>Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record</td>
<td>High</td>
</tr>
<tr>
<td>Population Management</td>
<td>Anticoagulant management improvements</td>
<td>High</td>
</tr>
<tr>
<td>Population Management</td>
<td>Glycemic management services</td>
<td>High</td>
</tr>
<tr>
<td>Population Management</td>
<td>Chronic care and preventative care management for empanelled patients</td>
<td>Medium</td>
</tr>
<tr>
<td>Population Management</td>
<td>Implementation of methodologies for improvements in longitudinal care management for high risk patients</td>
<td>Medium</td>
</tr>
<tr>
<td>Population Management</td>
<td>Implementation of episodic care management practice improvements</td>
<td>Medium</td>
</tr>
<tr>
<td>Population Management</td>
<td>Implementation of medication management practice improvements</td>
<td>Medium</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Implementation of use of specialist reports back to referring clinician or group to close referral loop</td>
<td>Medium</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Implementation of documentation improvements for practice/process improvements</td>
<td>Medium</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Implementation of practices/processes for developing regular individual care plans</td>
<td>Medium</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Practice improvements for bilateral exchange of patient information</td>
<td>Medium</td>
</tr>
<tr>
<td>Beneficiary Engagement</td>
<td>Use of certified EHR to capture patient reported outcomes</td>
<td>Medium</td>
</tr>
<tr>
<td>Beneficiary Engagement</td>
<td>Engagement of patients through implementation of improvements in patient portal</td>
<td>Medium</td>
</tr>
<tr>
<td>Beneficiary Engagement</td>
<td>Engagement of patients, family and caregivers in developing a plan of care</td>
<td>Medium</td>
</tr>
<tr>
<td>Patient Safety and Practice Assessment</td>
<td>Use of decision support and standardized treatment protocols</td>
<td>Medium</td>
</tr>
<tr>
<td>Achieving Health Equity</td>
<td>Leveraging a QCDR to standardize processes for screening</td>
<td>Medium</td>
</tr>
<tr>
<td>Integrated Behavioral and Mental Health</td>
<td>Implementation of integrated PCBH model</td>
<td>High</td>
</tr>
<tr>
<td>Integrated Behavioral and Mental Health</td>
<td>Electronic Health Record Enhancements for BH data capture</td>
<td>Medium</td>
</tr>
</tbody>
</table>
Advancing Care Information Measures (ACI)

- Counts for 25% of overall MIPS score
- A CEHRT (Certified Electronic Health Record Technology) is mandatory
  
  **Note:** PrognoCIS is certified for the current 2015 edition of ONC requirements.
- ACI measures are grouped into 3 sub-categories for a maximum total of 155 points
  - **5 Base Measures** – mandatory to receive credit for this category
  - **9 Performance Measures** – additional *Performance* points

**Notes:**
- *There are no pre-defined thresholds for the numerator. You may report just 1 patient if applicable; however, quantity does have an impact on your score.*
- *Each measure is scored against national benchmarks that will result in the number of points (from 1 to 10) the EC earns for each one*
- **3 Base measures also count as Performance measures.**
- **5 Bonus Measures** – optional additional points

**Notes:**
- **3 Performance measures also count as Bonus.**
- **18 Improvement Activities may quality for bonus points when they are tracked within the CEHRT.**
Advancing Care Information Measures

- There is no filtering required for ACI; there are 15 Core Objectives for this category

2017 Transitional Objectives are not supported.
ACI Measures for CEHRT 2015 Edition

• All 5 **Base** measures are mandatory to receive 50 points
  *Note: Failure to comply will result in an overall 0 API score for the category.*

• 6 additional **Performance** measures are available to achieve an additional 50 points
  *Note: 3 of the Base measures automatically count as Performance measures also.*

• 5 **Bonus** measures available for extra points
  *Note: 1 Performance measure automatically counts as a Bonus measure also.*

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Type</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Risk Analysis</td>
<td>Base</td>
<td>0</td>
</tr>
<tr>
<td>e-Prescribing</td>
<td>Base</td>
<td>0</td>
</tr>
<tr>
<td>Provide Patient Access</td>
<td>Base/Performance</td>
<td>10</td>
</tr>
<tr>
<td>Send a Summary of Care</td>
<td>Base/Performance</td>
<td>10</td>
</tr>
<tr>
<td>Request/Accept Summary of Care</td>
<td>Base/Performance</td>
<td>10</td>
</tr>
<tr>
<td>Patient-specific Education</td>
<td>Performance</td>
<td>10</td>
</tr>
<tr>
<td>View, Download, or Transmit (VDT)</td>
<td>Performance</td>
<td>10</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Performance</td>
<td>10</td>
</tr>
<tr>
<td>Patient-generated Health Data</td>
<td>Performance</td>
<td>10</td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td>Performance</td>
<td>10</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>Performance/Bonus</td>
<td>0 or 10</td>
</tr>
<tr>
<td>Syndromic Surveillance Reporting</td>
<td>Bonus</td>
<td>0</td>
</tr>
<tr>
<td>Electronic Case Reporting</td>
<td>Bonus</td>
<td>0</td>
</tr>
<tr>
<td>Public Health Registry Reporting</td>
<td>Bonus</td>
<td>0</td>
</tr>
<tr>
<td>Clinical Data Registry Reporting</td>
<td>Bonus</td>
<td>0</td>
</tr>
</tbody>
</table>
Weightage / Scoring
Performance Category Weights

- The weights assigned to each category are based on 1 to 100 points
- The overall MIPS score is a number of points calculated by the individual scores of each category and weighted to final score of 100%

Quality
60%

Cost
0%

Improvement Activities
15%

Advancing Care Information
25%

The following example uses random points based on partial participation minimums.
### Quality Category Scoring

- Counts for 60% of overall MIPS score
- CMS-defined **Performance Benchmarks** classified into “deciles”
- Benchmarks are specific to the data submission method and are based on 2015 PQRS reporting data
- EC will earn **from 3 to 10 points per measure** (not counting bonus points, based upon performance % within the applicable decile assigned)

<table>
<thead>
<tr>
<th>Decile</th>
<th>Performance Benchmark</th>
<th>Quality Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 3</td>
<td>&lt;5.31</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>5.31 - 10.90</td>
<td>3.3 - 3.9</td>
</tr>
<tr>
<td>4</td>
<td>10.91 - 19.99</td>
<td>4 - 4.9</td>
</tr>
<tr>
<td>5</td>
<td>20.00 - 29.26</td>
<td>5 - 5.9</td>
</tr>
<tr>
<td>6</td>
<td>29.27 - 38.77</td>
<td>6 - 6.9</td>
</tr>
<tr>
<td>7</td>
<td>38.78 - 50.09</td>
<td>7 - 7.9</td>
</tr>
<tr>
<td>8</td>
<td>50.10 - 62.60</td>
<td>8 - 8.9</td>
</tr>
<tr>
<td>9</td>
<td>62.61 - 76.16</td>
<td>9 - 9.9</td>
</tr>
<tr>
<td>10</td>
<td>&gt;= 76.17</td>
<td>10</td>
</tr>
</tbody>
</table>

**Example 1:**
- EC reports required data and gets a performance score of 5.25%
- This falls in the 1st decile, which is worth 3 points

**Example 2:**
- EC reports required data and gets a performance score of 78.25%
- This falls in the 10th decile, which is worth 10 points
Quality Category Scoring – Example

- A minimum of 3 points will be given for any amount of data submitted per measure
- The more data submitted, the higher potential points to be earned
- Bonus points are earned by submitting additional measures (beyond the 6 required)

The Points
- Measure 1 = 10 pts
  (Outcome measure)
- Measure 2 = 6 pts
- Measure 3 = 8 pts
- Measure 4 = 9 pts
- Measure 5 = 10 pts
- Measure 6 = 10 pts
- Measure 7 = 1 bonus

The Score
- 53 + 1 points
- ÷ 60 maximum
- =
- Quality = 90 points
**Improvement Activities Category Scoring**

- Counts for 15% of overall MIPS score
- Report up to **40 points** to receive full credit for this category
- 92 activities defined under 9 categories

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

- Each activity is weighted as **Medium** or **High**
  - Medium = 10 points
  - High = 20 points

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**Additional improvements in access as a result of QIN/QIO TA**

As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services (e.g., investment of on-site diabetes educator).

<table>
<thead>
<tr>
<th>ACTIVITY ID</th>
<th>SUBCATEGORY NAME</th>
<th>ACTIVITY WEIGHTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_EPA_4</td>
<td>Expanded Practice Access</td>
<td>Medium</td>
</tr>
</tbody>
</table>
**Improvement Activities Scoring – Example**

### Example 1
- **Report 3 activities**
- **Weightage:**
  - Medium → 2 x 10 pts = 20 pts
  - High → 1 x 20 pts = 20 pts

### Example 2
- **Report 2 activities**
- **Weightage:**
  - High → 2 x 20 pts = 40 pts
Improvement Activities Scoring – Example (cont’d)

- Counts for 15% of overall MIPS score
- Report activities that equal up to **40 points**

*Note: 18 of these also qualify towards ACI Bonus points (see ACI Scoring Example below).*

**Example 1 Points**
- IA 1 = 10 pts
- IA 2 = 10 pts
- IA 3 = 20 pts

**The Score**
- 40 points
- 40 maximum
- 100 possible
- **IA = 100 points**
Advancing Care Information Category Scoring

- Counts for 25% of overall MIPS score
- Score is calculated across 3 sub-categories worth maximum 155 points
  - **Base** score = 50 points

**Notes:**
- All 5 of these measures are mandatory, or no credit will be issued to the EC for this category at all.
- For users electing the “Test” (Minimal) Participation for a neutral payment adjustment, if ACI is chosen, you must report some data for each of the 5.

- **Performance** score = 90 points
- **Bonus** score = 15 points
  - 5 points for reporting 1 Public Health Reporting measures
    **Note:** The bonus points apply regardless of one, two, or all three PHR measures being fulfilled.
  - 10 points for reporting any of the specific 18 Improvement Activities within CEHRT
ACI Base Scoring – Example

- EC must fulfill the requirements of all five Base Score measures
- If requirements are not met, EC will get a 0 for overall ACI score*

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Objective Name</th>
<th>Performance Score Weight</th>
<th>Required for Base Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACI_TRANS__PPHI_1</td>
<td>Protect Patient Health Information</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>ACI_TRANS__EP_1</td>
<td>Electronic Prescribing</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>ACI_TRANS__PEA_1</td>
<td>Patient Electronic Access</td>
<td>Up to 20%</td>
<td>Yes</td>
</tr>
<tr>
<td>ACI_HIE_1</td>
<td>Health Information Exchange</td>
<td>Up to 10%</td>
<td>Yes</td>
</tr>
<tr>
<td>ACI_HIE_2</td>
<td>Health Information Exchange</td>
<td>Up to 10%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The Points

- 5 Base measures count as a whole; no point value is assessed to measures individually
- EC must attest Yes to the 1st measure (Security Risk Analysis)
- Numerator must be at least 1 or more for the other four measures

*The Score

ACI Base = 50 points
ACI Performance Scoring – Example

Provide Patient Access
- Base 3/Perf 1 = 10 pts
- Base 4/Perf 2 = 10 pts
- Base 5/Perf 3 = 10 pts
- Perf 3 = 10 pts
- Perf 4 = 7 pts
- Perf 5 = 8 pts
- Perf 6 = 8 pts
- Perf 7 = 10 pts
- Perf 8 = 7 pts
- Perf 9 = 10 pts

Send a Summary of Care

Request/Accept Summary of Care

Patient-Specific Education

View, Download and Transmit (VDT)

Secure Messaging

Patient-Generated Health Data

Clinical Information Reconciliation

Immunization Registry Reporting

The Points*
- Base 3/Perf 1 = 10 pts
- Base 4/Perf 2 = 10 pts
- Base 5/Perf 3 = 10 pts
- Perf 3 = 10 pts
- Perf 4 = 7 pts
- Perf 5 = 8 pts
- Perf 6 = 8 pts
- Perf 7 = 10 pts
- Perf 8 = 7 pts
- Perf 9 = 10 pts

The Score
ACI Performance = 90 points

*Each measure is worth from 1 up to 10 points based on benchmarks set by CMS.
ACI Performance Scoring – Example (cont’d)

- CMS has established **Performance Rates** for each measure
- Most measures are worth a maximum of **10 percentage points**
- Based on numerator/denominator submitted, 1% = 1 performance point
- The *Immunization Registry Reporting* measure is actually a *Yes/No* rather than a numerator/denominator result; thus, EC gets either **10 or 0 points**.

  **Note**: *This measure will also qualify towards Bonus points.*

![Performance Rate Table]

Performance Rate per Measure Example:

- Numerator/Denominator = 90/100
- Performance Rate = 90%
- ACI Performance Score = 9 points
**ACI Bonus Scoring – Example**

- Attesting **Yes** to 1 or more of the Public Health Reporting measures\(^\text{^}\) yields the EC a **5% Bonus**
- Attesting **Yes** to the completion of at least 1 or more of the specific 18 Improvement Activities using CEHRT results in a **10% Bonus**

**The Points**

- The *Immunization Registry Reporting Performance* measure also counts as a **Bonus measure worth 5 points\(^\text{^}\)**

**Note:** Whether you do only the 1, or if you do 2 or all 3 PHR measures, it is only worth 5 Bonus Points.

**The Score**

\(^\text{^}ACI \text{ Bonus} = 5 \text{ points}\)
Advancing Care Information Scoring – The Total

The Score
- Base – 50 points
- Performance – 90 points
- Bonus = 5 points

Total ACI = 145 points

Maximum Allowed ACI = 100 points
MIPS Composite Score

- The Final MIPS Score is calculated by combining the individual scores from all categories.

\[
\text{Quality} \times 90 \times 60\% = 54 \\
\text{IA} \times 40 \times 15\% = 15 \\
\text{ACI} \times 100 \times 25\% = 25
\]

\[
\text{MIPS score} = 54 + 15 + 25 = 94 \text{ points}
\]
MIPS Composite Score (cont’d)

- The Final MIPS Score determines the level of payment adjustment in 2019 for the EC
- Scores of 70 points or more allow for additional bonus incentive
- In our example, the score of 94 points qualifies for a positive adjustment + bonus potential due to participation beyond minimal requirements

<table>
<thead>
<tr>
<th>Final Score</th>
<th>Payment Adjustment</th>
</tr>
</thead>
</table>
| ≥70 points  | - Positive adjustment  
|            | - Eligible for exceptional performance bonus—minimum of additional 0.5% |
| 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 |

MIPS score = 94 points
Advanced APM Reporting
APM Overview

- [https://qpp.cms.gov/apms/overview](https://qpp.cms.gov/apms/overview)
- APMs are a payment approach that gives added incentive payments to qualified providers that provide high-quality and cost-efficient care
- An APM can apply to a specific clinic condition, care episode, or population
- To learn about and apply to join an APM, see: [https://innovation.cms.gov](https://innovation.cms.gov)
- Incentive payment of 5% for ECs who receive 25% of Medicare B payments through or see 20% of Medicare patients through the AAPM in 2017
- EC must also submit applicable eCQM (see Appendix D)

In 2017, the following models are Advanced APMs:

- [Comprehensive ESRD Care (CEC) - Two-Sided Risk](https://qpp.cms.gov/apms/overview)
- [Comprehensive Primary Care Plus (CPC+)](https://qpp.cms.gov/apms/overview)
- [Next Generation ACO Model](https://qpp.cms.gov/apms/overview)
- [Shared Savings Program - Track 2](https://qpp.cms.gov/apms/overview)
- [Shared Savings Program - Track 3](https://qpp.cms.gov/apms/overview)
- [Oncology Care Model (OCM) - Two-Sided Risk](https://qpp.cms.gov/apms/overview)
- [Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)](https://qpp.cms.gov/apms/overview)

Providers can register to participate and CMS will select/inform those they approve.
Meaningful Use/Medicaid
EHR Incentive Program

- Medicaid only
- 2016 was final year for EP to register/begin MU
- Determined by your state
- Choose to report either Modified Stage 2 or Stage 3 Objectives & Measures for 2017
- No payment adjustments
- Incentives are paid to EP for 6 years total (thru 2021)
- EP must also report applicable eCQM along with Core Objectives (see Appendix D)
### Medicaid Eligible Professionals

#### EHR Incentive Program Modified Stage 2

Objectives and Measures for 2017

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Updated: November 2016

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<tr>
<th>Eligible Professional Objectives and Measures</th>
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<tbody>
<tr>
<td><strong>(1)</strong> Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical capabilities.</td>
</tr>
<tr>
<td><strong>(2)</strong> Use <strong>clinical decision support</strong> to improve performance on high-priority health conditions.</td>
</tr>
<tr>
<td><strong>(3)</strong> Use <strong>computerized provider order entry (CPOE)</strong> for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.</td>
</tr>
<tr>
<td><strong>(5)</strong> <strong>Health Information Exchange</strong> – The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.</td>
</tr>
<tr>
<td><strong>(6)</strong> Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.</td>
</tr>
<tr>
<td><strong>(7)</strong> The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.</td>
</tr>
<tr>
<td><strong>(8)</strong> <strong>Patient Electronic Access</strong> – Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.</td>
</tr>
<tr>
<td><strong>(9)</strong> Use <strong>secure electronic messaging</strong> to communicate with patients on relevant health information.</td>
</tr>
<tr>
<td><strong>(10)</strong> <strong>Public Health Reporting</strong> – The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.</td>
</tr>
</tbody>
</table>
### Eligible Professional Objectives and Measures

| (1) | Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards. |
| (2) | Generate and transmit permissible prescriptions electronically (eRx). |
| (3) | Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions. |
| (4) | Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines. |
| (5) | **Patient Electronic Access** - The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education. |
| (6) | **Coordination of Care** - Use CEHRT to engage with patients or their authorized representatives about the patient’s care. |
| (7) | **Health Information Exchange** - The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT. |
| (8) | **Public Health Reporting** - the EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice. |
Appendices
Appendix A – Summary of Requirements for MIPS 2017

  - Minimum of 90 days data collection within 2017
  - Choose up to 6 measures, including 1 *Outcome* measure per method of data submission
  - If there is no *Outcome* measure applicable to your specialty/practice, choose a measure defined as High priority by CMS

- **Improvement Activities** ([https://qpp.cms.gov/mips/improvement-activities](https://qpp.cms.gov/mips/improvement-activities))
  - Yes/No attestation; no data to be collected
  - Select activities that best fit your practice
  - Complete up to 4 activities for a minimum of 90 days

- **Advancing Care Info** ([https://qpp.cms.gov/mips/advancing-care-information](https://qpp.cms.gov/mips/advancing-care-information))
  - Fulfill the required measures for a minimum of 90 days
  - 5 Base Measures (mandatory)
  - 9 Performance Measures
  - 3 Bonus Measures as applicable (Public Health Reporting)
  - Exemption available for measures that are not applicable to the EC

- **Cost**
  - N/A in 2017
Appendix B – *QPP Getting Started* Checklist

- Determine your eligibility
- Choose whether to report as an individual or as part of a group
- Select your data submission mechanism and verify its capabilities
- Verify your EHR vendor or registry’s capabilities before your performance period
- Choose your measures and activities for each category
- Decide your pace for reporting year 2017 based on desired payment adjustment in 2019
  - *No Participation* – negative 4% payment adjustment
  - *Test/Minimal Participation* – avoid payment adjustment; no bonus
  - *Partial Participation* – some positive bonus between 0 and less than 4%
  - *Full Participation* – up to the maximum bonus of 4%
- Verify the information you need to report successfully
- Record required data based on your patient care for the performance period
- Submit data between January 1 and March 31, 2018
  - Each category may be reported independent of one another
  - A different reporting period may be selected for each category
Appendix C – Group Reporting Payment Adjustments

- Payment adjustments are assigned by CMS to the combination of TIN/NPI regardless of whether the performance is measured at the individual or group level
- Each EC participating in MIPS via group will receive a payment adjustment based on the group’s performance; with the highest final score being applied when applicable:
  - EC who work in multiple practices during performance period (different NPI/TIN)
  - EC who submit data both as part of group and individually
- Any individual EC (per NPI) included in the group (per TIN) but otherwise excluded because they are not eligible for MIPS will not receive a payment adjustment, however, he/she may still participate for the sake of reporting quality data.
- Payment adjustment applies only to the Medicare B allowed charges billed by the group
Appendix D – Electronic Clinical Quality Measures

- [https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms](https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms)
- Requires ONC Certification
- Definitions change annually by CMS as per calendar year
- Applicable for Medicare MIPS → Quality → EHR-based Submission
- Applicable for Medicaid Meaningful Use → Attestation
Appendix E – QPP/MU Settings*

*Settings → Configuration → MU/QPP Settings

Applicable to all providers for both QPP & MU.

Each reporting provider must be defined.

Accordion UI reflects the selected provider’s programs & lets you manage the measures accordingly.
1. The **Reporting Period** will be entered when data is submitted/attestation (January 2018) to preserve the audit
2. User may **Search/Filter By** desired criteria to locate specific measures
3. Each measure selected will display a √.
4. The details section will display measure type, weightage, or category info.
5. Click in the **Info** column to view the requirements of the measure.
QPP/MU Reports

Reports → MU/QPP Reports

- Classification: 2017 – QPP-MIPS
  - QRDA1 and QRDA3*

  *QRDA reports may be downloaded & exported as .xml.

Note: Formerly known as NQF Measures; now referenced by CMS number.
Questions and Answers....