BASICS ON MACRA/ MIPS 2017

MACRA / MIPS ---- QPP -- Quality Payment Program

- Applies to every TIN/NPI combination – If a provider works at more than 1 practice, they have to meet the requirements at all practices. All incentives/Penalties are specific to the TIN/NPI combo.
- Will be eligible for additional + adjustments each year of the 1st 6 years of the program
- Future years – less flexibility, longer performance periods and increased levels of performance expected
- If a provider works at more than one practice, they have to meet at both practices – TIN/NPI Combination
- No registration required
- Score of at least 70 indicates "exceptional performers" , which earns a bonus from a special "bonus pool"
- Did not automatically grandfather in past registries. Approved registries will be announced in May

Eligibility

At least $30,000 in allowables for a given provider **AND** at least 100 patients

Exclusions

Can be exempt if at least 1 of the above 2 eligibility criteria are true

Parts to the Program

Quality

- Former PQR program
- Worth 60% in 2017 (for 2019 payment adjustment)

Cost

- Former Value Based Modifier
- Not being scored in 2017 (for 2019 payment adjustment)

Clinical Practice Improvement

- New Section
- 15% in 2017 (for 2019 payment adjustment)

Advancing Care Information

- Formerly Meaningful Use
- Worth 25% in 2017 (for 2019 payment adjustment)

Participation

For year 2017, affecting payment adjustment in 2019

Option 1: Do NOT Participate and qualify as eligible

Automatic NEGATIVE 4% adjustment

Option 2: MINIMUM Participation

- Avoids penalty
- Must submit **one** measure:
  - 1 Quality
  - 1 Improvement Activity
  - Required Measurements of Advancing Care Information Performance Category

Option 3: PARTIAL Submission

- Report for a MINIMUM of 90 days
- Earn a Neutral or Small Positive Adjustment
- Must submit:
  - >1 Quality measure **OR**
  - >1 Improvement Activity **OR**
  - Required Measures in Advanced Care Info Category
- 90 days CAN BE DIFFERENT for each category – doesn't have to be the same 90 days

Option 4: FULL YEAR Submission

- Potential for Moderate + Payment Adjustment
- Do all Requirements

QUALITY Measure – 60% (in 2017)

- Focus is PERFORMANCE
- Need at least 20 cases for each measure to qualify
- 2017 – minimum of 3 points awarded for each measure submitted
  - 6 Measures including 1 outcome OR High priority (if an outcome is not available) **OR**
  - 1 specialty specific measure set & 1 outcome

Outcome Measures Available:

- Cataracts: 20/40 or Better VA within 90 Days Post Cataract Surgery
- Cataracts: Complications within 30 days Post Cataract Surgery Requiring Additional Surgical Procedures (INVERSE)
- Cataracts: Improvement in Patient's Visual Function within 90 Days Post Cataract Surgery

- Cataracts: Patient Satisfaction within 90 Days Post Cataract Surgery
- Cataract Surgery: Difference between planned and final refraction
- Cataract Surgery: with Interoperative Complications (INVERSE)
- POAG: Reduction of IOP by 15% or documentation of plan of care

High Priority Measures Available: (if not listed above)

- Biopsy Follow Up
- Closing the Referral Loop: Receipt of Specialist Report
- Controlling High BP
- Diabetes: HbA1c Poor Control (>9%) (INVERSE)
- DR: Communication with Physician Managing Ongoing Diabetes Care
- Documentation of Current Meds in the Medical Record
- Use of High Risk Meds in the Elderly (INVERSE)

Additional Measures Available:

- ARMD: Counseling on Antioxidant Supplement
- ARMD: Dilated Macular Examination
- Diabetes: Eye Exam
- DR: Documentation of Presence/Absence of Macular Edema and Level of Severity of Retinopathy
- Pneumococcal Vaccination Status
- Preventive Care and Screening: Influenza Immunization
- Preventive Care and Screening: Tobacco Use: Screen/Cessation Intervention
- Preventive Care and Screening: Unhealthy Alcohol Use: Screen/Brief Counseling
- POAG: Optic Nerve Eval

Submission

- Submit via claims : 50% of all Medicare Part B patients
- Submit via registry: 50% of all patients (if using IRIS or MORE, they submit 100% of all patients already)

Calculating Score for Performance:

- 3-10% Performance – 1 pt
- 11-20% Performance – 2 pts
- 21-30% Performance – 3 pts, etc
- Cannot have a 0% performance rate

COST – 0% (in 2017)

- Calculated by CMS via claims database
- Nothing to report
- No longer quality based

CLINICAL IMPROVEMENT - 15% (in 2017) - ATTESTATION

- Medium Weighted Measure = 10 points
- High Weighted Measure = 20 points
- 40 total points for maximum credit
- Can do 4 improvements for 90 days – 2 high or 4 med, or 1 high/2 med
- Small practices (<15 Eligible Clinicians) only have to submit 2 – regardless of weight (get double points)
- 2017: at least 1 will meet the threshold
- If reporting as a GROUP, only 1 provider is required to complete the measure to get credit

Advancing Care Information (ACI) – 25% (in 2017)

50% credit by fulfilling 5 required measurements for 90 days. You only need to have at least 1 in the numerator to reach 12.5%

5 Required Measures:

- Security Risk Analysis (Y/N)
- E-Prescribe (Numerator/Denominator)
- Provide Portal Access (Num/Denom) (up to 20%)
- Send Summary of Care Documents (Num/Denom; up to 20%)
- Ref/Accept Summary of Care Documents (Num/Denom)

Additional Measures Available:

- Immunization Registry Reporting
- Medication Reconciliation (up to 10%)
- Patient Specific Education (up to 10%)
- Secure Messaging (up to 10%)
- Specialized Registry Reporting
- View/Download/Transmit by Patients (up to 10%)

Performance Score – Up to 9 measures (up to 10% each)

- 1-10% = 1%
- 11-20 = 2%
- 21-30 = 3% etc.