MACRA vs Meaningful Use
The Adventure Continues

The future of Health IT is here. Turn it on.
The objective of this session is to provide some basic understanding and direction for practices in preparation for the 2017 requirements as it relates to the Advancing Care Information performance category vs Meaningful Use.

The information provided in this presentation is only intended to be a general summary. It is not intended to take the place of either the written law.
MACRA vs Meaningful Use
Session Agenda

- Why MACRA?
- What is MACRA?
- How does MACRA relate to Meaningful Use?
- How can a practice prepare?
MACRA: Proposed Rules

• This session looks at *proposed rules*
• Information provided only intended to be a general summary
• It is not intended to take the place of either the written law or regulations
• Public commentary concluded (June 27, 2016)
• Final regulations published in November 2016
MODERN ART GALLERY

It's called PATH TO PAYMENT
What is MACRA?

- MACRA Medicare Access and CHIP Reauthorization Act of 2015
- Quality Payment Program
- Establishes new ways to pay physicians for caring for Medicare beneficiaries
- Path to value
What is MACRA?


What does Title 1 of MACRA do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over **volume**
- **Streamlines** multiple programs under the new **Merit-Based Incentive Payments System (MIPS)**
- **Provides bonus payments** for participation in **eligible alternative payment modes (APMS)**

MACRA is part of a broader push towards value and quality and
Transforming our healthcare system

3 goals for our health care system:

**BETTER** care
**SMARTER** spending
**HEALTHIER** people

Via a focus on 3 areas:

- Incentives
- Care Delivery
- Information Sharing

MACRA will be implemented through the “Quality Payment Program (QPP),” which includes two paths:

- The Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)
Who Will Participate In MIPS?

Eligible provider – Eligible clinician

Affected clinicians are called "MIPS eligible clinicians" and will participate in MIPS. The types of Medicare Part B eligible clinicians affected by MIPS may expand in future years.

**Years 1 and 2**
- Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

**Years 3+**
- Secretary may broaden Eligible Clinicians group to include others such as
  - Physical or occupational therapists,
  - Speech-language pathologists,
  - Audiologists,
  - Nurse midwives,
  - Clinical social workers,
  - Clinical psychologists,
  - Dietitians / Nutritional professionals
Who Will Participate in MIPS?

All MIPS Eligible Clinicians

Participating as an...

Individual

or

Group

Those Not Eligible

Include: Hospitals, Facilities & Medicaid
Who will NOT Participate in MIPS?

- There are 3 groups of clinicians who will NOT be subject to MIPS

Medicare billing charges less than or equal to $10,000 \textbf{and} provides care for 100 or fewer Medicare patients in one year

Note: \textit{MIPS does not apply to hospitals or facilities}
MIPS – First Step to a Fresh Start

- MIPS is a new program
  - Streamlines 3 currently independent programs to work as one and to ease clinician burden.
  - Adds a fourth component to promote ongoing improvement and innovation to clinical activities.

- MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.

There are currently multiple individual quality and value programs for Medicare physicians and practitioners:

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier
- Medicare EHR Incentive Program

MACRA streamlines those programs into MIPS:

Merit-Based Incentive Payment System (MIPS)
The MIPS composite performance score will factor in performance in 4 weighted performance categories on a 1-100 point scale.

- **PQRS** (Quality): 50%
- **TCPI** (Resource use): 10%
- **PCMH** (Clinical practice improvement activities): 15%
- **MU** (Advancing care information): 25%

**ACI replaces MU for participants in MIPS**
MIPS: Advancing Care Information

Rajiv Leventhal
@RajivLeventhal

Has #MACRA killed #meaningfuluse? The name has been replaced with "Advancing Care Information," but the devil will be in the details

RETWEET  |  LIKES
---       | ---
1         | 2

6:11 PM - 27 Apr 2016

Reply to @RajivLeventhal

Gabriel Perna @GabrielSPerna · Apr 27
@RajivLeventhal I think makeover is the better word

Rajiv Leventhal @RajivLeventhal · Apr 27
@GabrielSPerna Agreed, we have heard MU is dead before---until it's not
MIPS: Advancing Care Information Performance Category

The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points.
MIPS: Advancing Care Information Performance Category

**MIPS weight**
- 25% of total MIPS score
- May be reduced if >75% of clinicians are successful
- 12-month physician reporting period

**Base measures and scoring**
- 50 points for achieving 6 objectives (pass/fail)
- Immunization registry reporting required; reporting to more than one public health registry earns bonus point
- CPOE and clinical decision support no longer required
- Provide numerator/denominator or yes/no attestation for each
- Failure to attest to “protecting patient health information” results in zero total ACI score

**Performance measures and scoring**
- 80 points available; total combined score exceeding 100 gets full credit
- Clinicians select from measures across 3 objective areas: patient electronic access, patient engagement, HI exchange
- ACI performance category will be reweighted to zero and other MIPS categories increased if objectives don’t apply (e.g., for hospital-based clinicians)
- Clinical quality measures from Meaningful Use no longer required
MIPS: Advancing Care Information Performance Category

Base Score
Accounts for 50 points of the total Advancing Care Information category score.

To receive the base score, physicians must simply provide the numerator/denominator or yes/no for each objective and measure
CMS proposes six objectives and their measures that would require reporting for the base score:

- **Protect Patient Health Information** (yes required)
- **Electronic Prescribing** (numerator/denominator)
- **Patient Electronic Access** (numerator/denominator)
- **Coordination of Care Through Patient Engagement** (numerator/denominator)
- **Health Information Exchange** (numerator/denominator)
- **Public Health and Clinical Data Registry Reporting** (yes required)
MIPS: Advancing Care Information Performance Category

Advancing Care Information
1. Protect Patient Health Information
2. Electronic Prescribing
3. Patient Electronic Access
4. Coordination of Care through Patient Engagement
5. Health Information Exchange
6. Public Health and Clinical Data Registry Reporting

Meaningful Use Stage 3
1. Protect Patient Health Information
2. eRx
3. Patient Electronic Access
4. Coordination of Care through Patient Engagement
5. Health Information Exchange
6. Public Health and Clinical Data Registry Reporting
7. Clinical Decision Support
8. CPOE

Quality Component of MIPS
<table>
<thead>
<tr>
<th>MU</th>
<th>NPRM</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% score required on all</td>
<td>Pass-fail program replaced with base and</td>
<td>50 point base score threshold still 100%;</td>
</tr>
<tr>
<td>measures to avoid 5% penalty</td>
<td>performance scoring</td>
<td>security attestation required</td>
</tr>
<tr>
<td></td>
<td>Measures reduced</td>
<td>Remaining MU measures unchanged; simply</td>
</tr>
<tr>
<td></td>
<td>Performance score thresholds eliminated</td>
<td>reorganized</td>
</tr>
<tr>
<td></td>
<td>Public health registry reporting reduced</td>
<td>MU exclusions eliminated</td>
</tr>
<tr>
<td>Included redundant measures and</td>
<td></td>
<td>Full-year reporting</td>
</tr>
<tr>
<td>problematic CPOE, CDS and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>clinical quality measures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ACI Base Score Measures

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Total Base Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Assessment</td>
<td></td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>ePrescribing</td>
<td></td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>- Patient Access</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Patient-Specific Education</td>
<td></td>
</tr>
<tr>
<td>Coordination of Care Through Patient Engagement</td>
<td>- View, Download or Transmit (VDT)</td>
<td></td>
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<tr>
<td></td>
<td>- Secure Messaging</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Patient-Generated Health Data</td>
<td></td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>- Patient Care Record Exchange</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Request / Accept Patient Care Record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Clinical Information Reconciliation</td>
<td></td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>- Immunization Registry Reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Syndromic Surveillance Reporting (optional)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Electronic Case Reporting (optional)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Public Health Registry Reporting (optional)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Clinical Data Registry Reporting (optional)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>
**THE PERFORMANCE SCORE**

The performance score accounts for up to 80 points towards the total Advancing Care Information category score.

Physicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

- Patient Electronic Access
- Coordination of Care Through Patient Engagement
- Health Information Exchange
## Sample Performance Score

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Patient Electronic Access</th>
<th>Coordination of Care Through Patient Engagement</th>
<th>Health Information Exchange (HIE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measures</td>
<td>Patient Access</td>
<td>Patient-Specific Education</td>
<td>VDT</td>
</tr>
<tr>
<td>Performance Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33%</td>
<td>31%</td>
<td>25%</td>
<td>38%</td>
</tr>
<tr>
<td>Percentage Points</td>
<td>9.5%</td>
<td>6.5%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Performance Score = 36.5 percent
## MIPS: Advancing Care Information Performance Category

### Sample Total Score

<table>
<thead>
<tr>
<th>Base Score</th>
<th>Performance Score Components</th>
<th>Total Performance Score</th>
<th>Public Health and Clinical Data Registry Bonus Point</th>
<th>Total Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information Objectives and Measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient Electronic Access</td>
<td>Coordination of Care Through Patient Engagement</td>
<td>Health Information Exchange</td>
<td>Total Performance Score</td>
</tr>
<tr>
<td>50%</td>
<td>9.5%</td>
<td>6.5%</td>
<td>3.3%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

87.5% of 25 possible percentage points = 21.88 percentage points for the advancing care information performance category.
100% score required on all measures to avoid 5% penalty

Included redundant measures and problematic CPOE, CDS and clinical quality measures

Pass-fail program replaced with base and performance scoring

Measures reduced

Performance score thresholds eliminated

Public health registry reporting reduced

50 point base score threshold still 100%; security attestation required

Remaining MU measures unchanged; simply reorganized

MU exclusions eliminated

Full-year reporting
Summary:

- Scoring based on key measures of health IT interoperability and information exchange.
- Flexible scoring for all measures to promote care coordination for better patient outcomes.
- Key Changes from Current Program (EHR Incentive):
  - Dropped “all or nothing” threshold for measurement
  - Removed redundant measures to alleviate reporting burden
  - Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives
  - Reduced the number of required public health registries to which clinicians must report
  - Year 1 Weight: 25%
Calculating the Composite Performance Score for MIPS

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

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

MIPS Composite Performance Score (CPS)

The CPS will be compared to the MIPS performance threshold to determine the adjustment percentage the eligible clinician will receive.
MIPS composite performance scoring method that accounts for:

- Weights of each performance category
- Exceptional performance factors
- Availability and applicability of measures for different categories of clinicians
- Group performance
- The special circumstances of small practices, practices located in rural areas and non-patient-facing MIPS eligible clinicians

Unified scoring system:

- Converts measures/activities to points,
- Eligible Clinicians will know in advance what they need to do to achieve top performance and
- Partial credit available
## Calculating the Composite Performance Score for MIPS

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
<th>Description</th>
</tr>
</thead>
</table>
| Advancing Care Information            | 25%    | - Base score of 60 points is achieved by reporting at least one use case for each measure  
- Up to 10 additional performance points available per performance measure  
- Total cap of 100 percentage points available |
| Quality                               | 50%    | - Clinicians choose 6 measures to report to CMS that best reflect their practice.  
- Each measure 1-10 points compared to historical benchmark (if available)  
- 0 points for a measure that is not reported  
- 80-90 points depending on group size  
- Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR report  
- Measures are averaged to get a score for the category |
| Clinical Practice Improvement         | 15%    | - Each activity worth 10 points  
- Over 90 activities from which to choose  
- Double weight for “high” value activities  
- Clinicians participating in medical homes earn full credit in this category  
- Those participating in Advanced APMs will earn at least have credit  
- Sum of activity points compared to a target |
| Resource Use                          | 10%    | - Average score of all cost measures that can be attributed  
- CMS will calculate these measures based on claims and availability of sufficient volume  
- Clinicians do not need to report anything |
The potential maximum adjustment % will increase each year from 2019 to 2022.

MIPs payment adjustments are required to be budget neutral. This means that rather than additional spending, higher reimbursement for those who score well will come from reduced payments to those with poorer performance.
# MACRA Proposed Rule MIPS Timeline

<table>
<thead>
<tr>
<th>2017</th>
<th>2018</th>
<th>July</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Period (Jan-Dec)</td>
<td>Reporting and Data Collection</td>
<td>2\textsuperscript{nd} Feedback Report (July)</td>
<td>Targeted Review Based on 2017 MIPS Performance</td>
<td>MIPS Adjustments in Effect</td>
</tr>
<tr>
<td>1\textsuperscript{st} Feedback Report (July)</td>
<td></td>
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<td></td>
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</tbody>
</table>

**Analysis and Scoring**
1. The Quality Payment Program changes the way Medicare pays clinicians and offers financial incentives for providing high value care.

2. Medicare Part B clinicians will participate in the MIPS, unless
   • they are in their 1st year of Part B participation,
   • become QPs through participation in Advanced APMs, or
   • have a low volume of patients

3. Contains components consistent with MU Stage 3

4. Payment adjustments and bonuses will begin in 2019

5. Begin preparation now!

Focus on lessening the burden of keeping score and increase the focus on providing increased patient care.
MACRA Proposed Rule
How Can You Prepare?

1. Participate in available webinars (National, local, HIMSS, RECs, HIEs, etc.)
2. Initiate Community of Care / Community of Practice meetings
3. Use professional society resources
4. Review and analyze MU and Quality reports
5. Patient Engagement Playbook
6. Participate in TCPI and/or PCMH
7. GA-HITEC assistance
8. Determine which track is best for your practice
9. Determine risk
10. GA-HITEC supporting Technical Assistance for ACI
11. Allocation of $20 million/year from 2016-2020 to small practices to provide technical assistance regarding MIPS performance criteria or transitioning to an APM
12. Begin preparation now!
MODERN ART GALLERY

It’s called PATH TO PAYMENT
Resources

- **Centers for Medicare and Medicaid Services**
  - [www.cms.gov/ehrincentiveprograms](http://www.cms.gov/ehrincentiveprograms)
  - [http://go.cms.gov/QualityPaymentProgram](http://go.cms.gov/QualityPaymentProgram)
- **Office of the National Coordinator**
  - [www.health.gov](http://www.health.gov)
- **Georgia Health Information Network (GaHIN)**
  - [www.gahin.org](http://www.gahin.org)
- **Georgia Quality Improvement Organizations (QIOs)**
- **Georgia Transforming Clinical Practice Initiative (TCPI)**
- **Practice Transformation Networks (PTNs)**
The future of Health IT is here. Turn it on.