MACRA and MIPS: Strategies for Success

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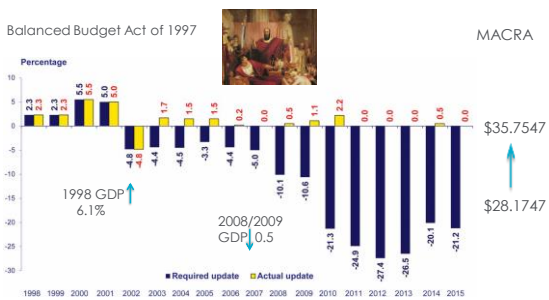
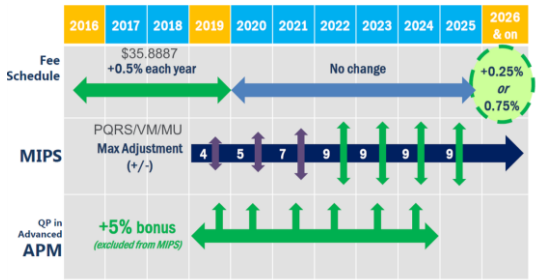
The SGR (Sustainable Growth Rate) Reality

The Big Picture: CMS Payment Evolution



HMMM…How Does MACRA Make The SGR Go Away?

Payment Timeline of MACRA/MIPS



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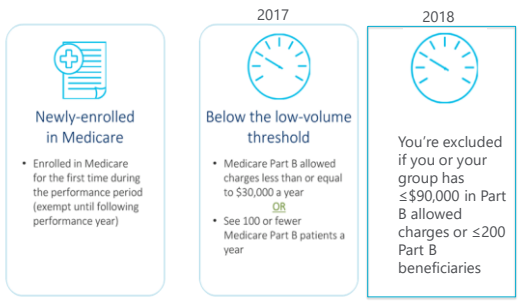
Is MIPS a Big Deal? Economic Impact of MIPS

Year	Percentage	40k ED	60k ED	80k ED
2019	4%	$48,000	$72,000	$96,000
2020	5%	$60,000	$90,000	$120,000
2021	7%	$84,000	$126,000	$168,000
2022+	9%	$108,000	$162,000	$216,000

MIPS Participation: Physician & NP/PA



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2017/2018 MIPS Provider Participation

- While more than half of clinicians (roughly 780,000) billing under the Medicare PFS will be excluded from MIPS, **most EM physicians will be subject to MIPS**

Specialty	Newly Enrolled	Low Volume	Total Exclusions	Total Inclusions
Emergency Medicine 67,469	**2,995 (4.4%)**	**22,348 (33.1%)**	**25,684 (38.1%)**	**41,785 (61.9%)**

2017 CMS MIPS/APMs Final Rule Table 58

2018 Final Rule estimates 36,522 MIPS eligible clinicians (54.1%)

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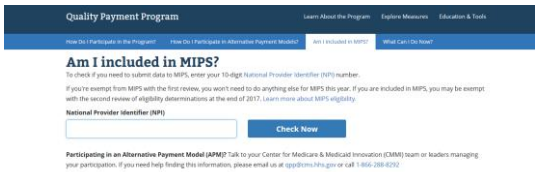
NPI Look-Up Tool



https://qpp.cms.gov/learn/eligibility

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MIPS Structure

Blends Together 3 CMS programs: PQRS, Value Modifier, and EHR Meaningful Use

Four Components of the MIPS Composite Score

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2017/2018 Advancing Care Information (25%) Hospital Based Exemption Detail

Section 1848(a)(7)(D) of the Act exempts hospital-based EPs from the meaningful use payment adjustment.

"We defined a hospital-based EP as furnishing 75% of his/her services in sites of service identified as an inpatient hospital or emergency room in the year preceding the payment year, Claims with Place of Service Codes 21 (inpatient hospital), 22 (outpatient hospital), or 23 (emergency department) are considered hospital-based."

Reweighting to Quality

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2017/2018 Cost Category Final Rule Weighting

"We believe that a transition period would be appropriate; we are lowering the weight of the cost performance category for the first and second MIPS payment years. We are finalizing a weighting of 0% for the transition year and 10 percent for the second MIPS payment year."

CMS MACRA Final Rule p.630/2398

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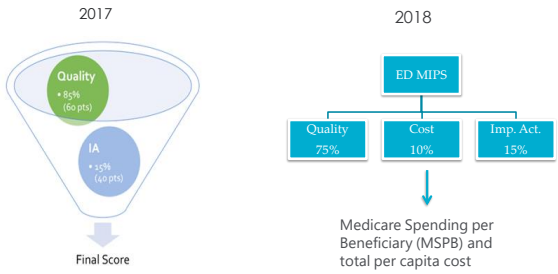
2017/2018 ED MIPS Scoring Simplified



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2017/2018 Data Submission Mechanisms

Quality	Claims ☆ QCDR Qualified Registry EHR
Resource Use	Administrative Claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified Registry EHR
Improvement Activities	Attestation ☆ QCDR Qualified Registry EHR

2017/2018 MIPS: Quality

- Report up to **6 quality measures**, including **one outcome/high priority measure**, for a minimum of 90 days (or a specialty measure set)
  - High priority measures:
    - Outcome (beyond the required outcome measure)
    - Appropriate use
    - Efficiency
    - Care coordination
    - Patient safety
    - Patient experience

Groups may use facility-based measurement and elect their hospital value base purchasing score in 2019

MIPS: Quality Reporting 2017/2018 Data Completeness Threshold

Category	Claims	Qualified Registry	Qualified Clinical Data Registry (QCDR)	Certified EHR Technology
2017 Quality	50% of Medicare Part B patients	50% of ALL patients	50% of ALL patients	50% of ALL patients
2018 Quality	60% of Medicare Part B patients	60% of ALL patients	60% of ALL patients	60% of ALL patients

MIPS: Quality
Classes of Measures for 2017/2018

Class I: Measures scored based on performance

- The measure has a benchmark
- Has at least 20 cases
- Meets the data completeness standard 2017 50%; 2018 60%
- Receive 3 to 10 points based on performance compared to the benchmark (2017/2018)

Class 2: Measures assigned a flat score of 3 points for 2017

- Do not have a benchmark
- Does not have 20 cases
- Does not meet data completeness criteria
  - 2018 flat score 1 point

2017 Crafting A Solution
For The 85% Quality Reporting

2017 Emergency Medicine Specialty Measure Set

Measure #	Measure Title	EM CPT Codes	Claims	Registry/ QCDR	CEHRT
47	Care Plan (NOTE: **POS 23** Excluded)	NO	X	X	
66	Appropriate Testing for Children with Pharyngitis	X	NO	X	X
91	Acute Otitis Externa (AOE): Topical Therapy	X	X	X	
93	Acute Otitis Externa (AOE): Systemic Abx. Avoidance of Inappropriate Use	X	X	X	
116	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis **(18-64)**	X	NO	X	
130	Documentation & **Attestation of ALL RX & OTC** Medications	NO	X	X	X
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation	NO	X	X	X
254	Ultrasound Determination of Pregnancy Location for **Pregnant Patients** with Abdominal Pain	X	X	X	
255	Rhogham for Rh-Negative **Pregnant Women** at Risk of Fetal Blood Exposure	X	X	X	
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented	X	X	X	X
402	Tobacco Use and Help with Quitting Among **Adolescents**	NO		X	
415*	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	X	X	X	
416	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged **2 through 17 Years**	X	X	X	
431	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	NO	NO	X	
374	Closing the Referral Loop: Receipt of Specialist Report [EHR only measure]	NO	NO		X

2017 The Emergency Measure Set Reality

- Measures in the measures set <u>without ED codes</u>
  - #47 Care Plan, #130 Documentation of medications, #226 Tobacco cessation screening, #374 Closing the referral loop, #402 Tobacco use adolescents, #431 Alcohol abuse screening
- Measures in the Emergency Medicine set WITH 9928X codes, but <u>NOT reportable via CLAIMS</u>
  - #66 Testing for children what pharyngitis, #116 Avoidance of antibiotic use for adults with bronchitis

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Measures in the Emergency Medicine set WITH 9928X codes AND reportable via CLAIMS

- N > 20 at the NPI level if reporting via claims
- #91- Otitis externa topical therapy
- #93- Otitis externa avoiding PO Abx
- # 254- US determination of pregnancy location w/ abdominal pain
- #255- Rhog. for RH- at risk for fetal blood exposure
- #416- Head CT for minor blunt trauma 2-17 years old
- #415- Head CT for minor blunt trauma 18 years old
- # 317- Screening for hypertension

ACEP Letter to CMS Requesting MAV like Clinical Cluster

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ACEP Discussion with CMS

- ACEP/CMS phone conference reviewing ED measure set
- March 8th follow-up letter explaining scoring implications
- MAV type clinical cluster validation requested

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Scoring The Quality Measures

- CMS has released performance benchmarks for each measure on the qpp website:
  https://qpp.cms.gov/resources/education
  - Not all measures will have a benchmark
  - If measure can be reliably scored against benchmark, clinician can get 3-10 points
  - If no benchmark, clinician only gets 3 points
  - Get 3 points for just reporting some data

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Benchmarking Example – Measure #317

Benchmark Decile	Quality Measure #317 Percentage	Possible Points
Decile 1		3
Decile 2		3
Decile 3	42.3-50.44	3.0-3.9
Decile 4	50.45-59.06	4.0-4.9
Decile 5	59.07-68.11	5.0-5.9
Decile 6	68.12-78.63	6.0-6.9
Decile 7	78.64-92.67	7.0-7.9
Decile 8	92.68-99.53	8.0-8.9
Decile 9	99.54-99.99	9.0-9.9
Decile 10	100	10

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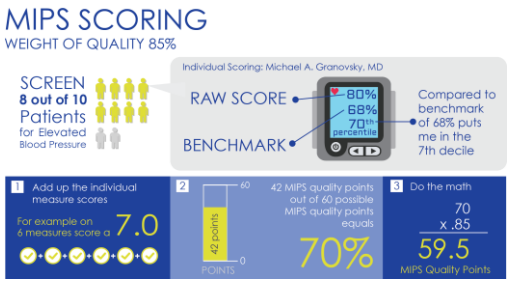
MIPS Quality Measure Scoring Detail



An Epidemic of Pregnant Medicare Patients?

- Draft and final CMS Clinical Cluster for Emergency Care
- Only had pregnancy related measures #254/#255
- June 20th letter to CMS

Claims Based Clusters

2016

Cluster Number	Cluster Title	Measure Number	Domain	Measure Title
4	Emergency Care	54	Effective Clinical Care	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain
		254	Effective Clinical Care	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain
		255	Effective Clinical Care	Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure

2017 Eligible Measure Applicability (EMA) for Claims Data Submission

4	Emergency Care	254	N/A	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain
		255	N/A	Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure

Anyone with Anything at Anytime

Eligible Measure Applicability (EMA)

- The EMA process only used with claims or qualified registry data submissions. Not with Qualified Clinical Data Registry (QCDR) and Certified Electronic Health Record Technology (CEHRT)
- **Step 1: Clinical Relation Test** sees if there are more clinically related quality measures based on the one to five quality measures you submitted. **OR**
- **Clinical Relation and Outcome/High Priority Test** if none of the six or more quality measures you submitted are an outcome or high priority measure, this test sees if any are clinically related to an outcome or high priority.

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The #317 Conundrum

16	General Care	130	High Priority	Documentation of Current Medications in the Medical Record
		226	N/A	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
		134	N/A	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
		317	N/A	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Note: *When submitting #130 and/or #226, they are not subject to EMA for these clinically related measures. It is expected to submit #130, #226, if quality measures if #134 and/or #317 is submitted.*

130- no 9928x codes
226- no 9928x codes (but yes 99406/07)
134- no 9928x codes

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CMS Response

- If a provider submits measure 317 along with CPT codes 99281-99285, does the clinical relation test require the provider report measures 130 and 226 in this General Care cluster, even though these measures cannot be scored for that provider as they have no applicable denominator?
- For claims EMA, if a submitted measure is clinically related to other measures, the eligible clinician would be analyzed by the Minimum Threshold Test to determine if there were 20 **denominator eligible encounters**. Analysis performed would verify the CPT codes billed and identify if the eligible clinician would **not be eligible to report 130 and 226 because of the lack of denominator-eligible patients**.

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The Other 15%
Improvement Activities

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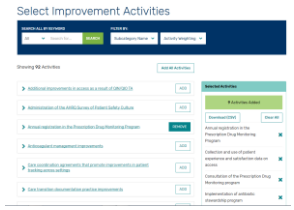
2017/2018 Improvement Activities (15%)

- 2017 92 activities across 8 categories
- Activity worth 20 pts. (High weight) or 10 pts (Medium weight)
- Want to score 40 points
- Activity must be implemented at least 90 days
- Need to specifically document activities for audit purposes



https://qpp.cms.gov/mips/improvement-activities

2018- 21 new Improvement Activities (CDC Training Courses Opioid and Abx)

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2017 /2018 Per CMS: The Minimum

2017

Test Pace

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Submit Something

- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

You Have Asked: ***"What is a minimum amount of data?"***

1 Quality Measure

OR

1 Improvement Activity

2018- Need a path to 15 MIPS points to avoid a penalty
-Improvement Activities
-Data Completion for 6 Quality Measures

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MIPS Next Steps

- 2017- CMS cluster guidance – preform some quality reporting
- 2017- Should have already initiated Improvement Activities
- 2018 MACRA Rule:
  - Thresholds to avoid penalties raised slightly
    - Need 15 points
- 2019 likely allows facility Value Based Purchasing Hospital Score to apply to ED docs who opt in

Stay Tuned!

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Contact Information

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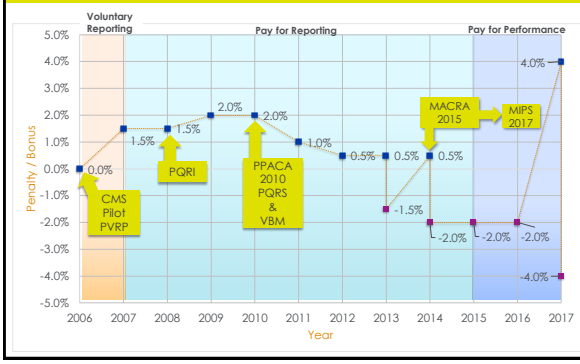
Educational Appendix

Evolution of Quality Programs



Who Is Required to Participate in MIPS?

- **Medicare physicians**
  - Doctor of Medicine
  - Doctor of Osteopathy
  - Doctor of Podiatric Medicine

FT, PT, moonlighters

- **Practitioners**
  - Physician Assistant**
  - Nurse Practitioner **
  - Clinical Nurse Specialist
  - Certified Registered Nurse Anesthetist
  - Certified Nurse Midwife
  - Clinical Social Worker

Reporting issue if no qualifying Pts.

PQRS Legislative Forces and Background

- **(PVRP)** Physician Voluntary Reporting Program
  - Pilot program for 2006
- Tax Relief and Health Care Act of 2006 (TRHCA)
  - 2007 created Physician Quality Reporting Initiative **(PQRI)**
- 2008 Congressional bill (MIPPA) made PQRI program permanent- transitioned to current **PQRS** Physician Quality Reporting System
- Affordable Care Act mandated- Value based modifier program **(VBM)**
- 2015 Medicare Access and CHIP Reauthorization Act of (MACRA) created Merit-based Incentive Payment System (MIPS)

Medicare Cost Methodology

- **Total Per Capita Costs for All Beneficiaries**, evaluates all Medicare Part A and B costs associated with any beneficiary over a year. Relies on a 2-step attribution methodology triggered by the group that provides the plurality of primary care services (as measured by allowable charges). A MIPS eligible clinician must have a minimum or 20 cases attributed to them to be scored. CMS will apply a specialty adjustment to this measure since it found, when implementing this measure as part of the VM, that there were widely divergent costs among patients treated by various specialties.

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Medicare Cost Methodology

- **Medicare Spending per Beneficiary**, evaluates Part A and B costs spanning an episode defined as 3 days prior and 30 days after an inpatient hospitalization. Beneficiaries are attributed to the group that provided the plurality of all Part B services during the inpatient stay (as measured by allowable charges) so it's not just limited to primary care services. When CMS evaluates the inpatient stay for attribution purposes, it looks at Part B services provided in an acute care setting that were provided the same day as the admission until the day of discharge so this could include ED services provided prior to the patient being admitted.

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Medicare Cost Methodology

- **Medicare Spending per Beneficiary (cont.)** If an ED clinician or TIN contributed to the plurality of a patient's part B costs during that inpatient stay, they would be held accountable for the entire cost of the MSPB episode (which is 3 days prior until 30 days post hospital stay). A MIPS eligible clinician must have a minimum or 35 cases attributed to them to be scored. Note that CMS will NOT adjust the MSPB measure by specialty since it is already adjusted on the basis of the index admission diagnosis-related groups (DRGs), which is likely to differ based on the specialty of the clinician attributed to the measure. CMS believes this adjustment adequately differentiates patient populations by different specialties.

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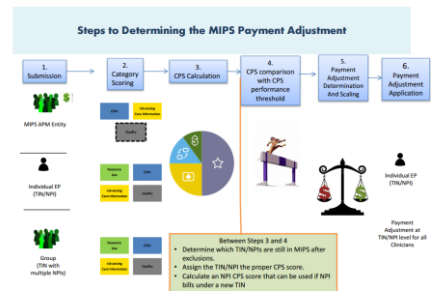
2017 Scoring- CMS Simplicity



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