

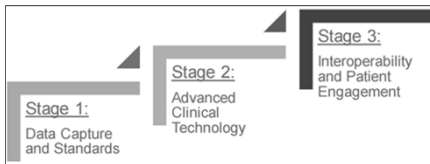
Meaningful Use and the Merit-Based Incentive Payment System 2017 and 2018

Meaningful Use Program Review

What is Meaningful Use?


Meaningful use as defined by CMS is using certified electronic health record (EHR) technology to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, population and public health
- Maintain privacy and security of patient health information




Who Can Participate?

Eligible Hospitals




Eligible Professionals
(Medicaid Only)




Who Can Participate?

Eligible Hospitals can participate in **both** programs.

Medicare EHR Incentive Program	Medicaid EHR Incentive Program
 <ul style="list-style-type: none"> • "Subsection (d) hospitals" in the 50 states or DC that are paid under the Inpatient Prospective Payment System (IPPS) • Critical Access Hospitals (CAHs) • Medicare Advantage (MA-Affiliated) Hospitals 	<ul style="list-style-type: none"> • Acute care hospitals (including CAHs and cancer hospitals) with at least 10% Medicaid patient volume • Children's hospitals (no Medicaid patient volume requirements)

Who Can Participate?



Medicaid Eligible Professionals

Medicaid EHR Incentive Program

- Physicians
- Dentists
- Certified nurse-midwives
- Nurse practitioners
- Physician Assistants practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Center (RHC) led by a physician assistant.
- **30% Medicaid patient volume (20% for Pediatricians)**

*Providers who don't bill Medicare Part B no longer need to attest once you have received all incentives. Only continue attesting to Medicaid if incentives are available.

MU or MIPS – Where Do I Fit?

Reporting MIPS & MU
If an EC meets the 30% Medicaid patient volume requirement (20% for peds), report to both MIPS and Medicaid MU if the EC has not claimed all Medicaid incentive dollars.

Reporting entity	MU	MIPS
Eligible hospital	X	
Critical access hospital	X	
Eligible clinician (Medicare)		X
Eligible clinician (Medicaid with Medicare services)	X	X
Eligible clinician (Medicaid)	X	
Eligible clinician in Advanced APM		

Modified Meaningful Use 2017 and 2018 - Medicare/Dual Attestation*

MU OBJECTIVE	MEASUREMENT
1 CPOE (Med, Lab, Radiology)	Removed
2 CDS with Interaction Checking	Removed
3 Patient Specific Education	10%
4 Medication Reconciliation	50%
5 View/Download/Transmit	Measure #1: 50% ; Measure #2: 1 Patient
6 Summary Care for Transitions	10% Sent Electronically
7 Security	Y/N
8 eRx with Drug Formulary	10%
9 Public Health Submission	3 of 4
10 Immunization Data	Active Engagement
11 Reportable Lab Results (EH only)	Active Engagement
12 Syndromic Surveillance	Active Engagement
13 Specialized Registry	Active Engagement

90 Day Reporting Period for all EPs/CAHs in 2017.
EPs who bill Medicaid Part B services will report through MIPS.
*Dual-eligible EPs/CAHs that submit attestation via the state rather than CMS will attest to the "Medicaid Only" measures in 2017 and beyond.

Modified Meaningful Use 2017 Medicaid Only

MU OBJECTIVE	MEASUREMENT
1 CPOE (Med, Lab, Radiology)	60% (Med), 30% (Lab), 30% (Rad)
2 CDS with Interaction Checking	5 CDS Interventions (4 related to CQMs)
3 Patient Specific Education	10%
4 Medication Reconciliation	50%
5 View/Download/Transmit	Measure #1: 50% ; Measure #2: 5%
6 Summary Care for Transitions	10% Sent Electronically
7 Security	Y/N
8 eRx with Drug Formulary	10% (EH) 50% (EP)
9 Secure Messaging (EP only)	5%
10 Public Health Submission	3 of 4 (EH) / 2 of 3 (EP)
11 Immunization Data	Active Engagement
12 Reportable Lab Results (EH only)	Active Engagement
13 Syndromic Surveillance	Active Engagement
14 Specialized Registry	Active Engagement

Inpatient Prospective Payment System (IPPS) Changes to Meaningful Use in 2018

- **Meaningful Use Stage 3**
 - All providers (EH and CAH) reporting to Medicare or Medicaid and EPs seeking Medicaid incentives will have a 90 day reporting period in 2018.
 - CMS has finalized a 2014/2015 CEHRT flexibility option in 2018.
 - This means that MU eligible providers will still be able to attest to Modified Stage 2 measures in 2018.
- **Inpatient Quality Reporting Program (IQR)**
 - IQR will allow 2014/2015 CEHRT flexibility in 2018.
 - IQR will only require 4 eCQMs to be submitted electronically in 2017 and 2018 for one self-selected quarter.

MU Staging Finalized


Provider Type	Calendar Year (EH & EP)				
	2014	2015	2016	2017	2018
Eligible Hospitals & Critical Access Hospitals	Stage 1 or Stage 2	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3
Eligible Professionals (Medicaid)	Stage 1 or Stage 2	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3
Eligible Clinicians (Medicare)	Stage 1 or Stage 2	Modified Stage 2	Modified Stage 2	MIPS	MIPS


2014 Certified EHR (points to 2014 column)
 2014 or 2015 Certified EHR (points to 2016 column)
 2014 or 2015 Certified EHR (points to 2017 column)

*90 day reporting period in both 2017 and 2018 for Meaningful Use attestation.

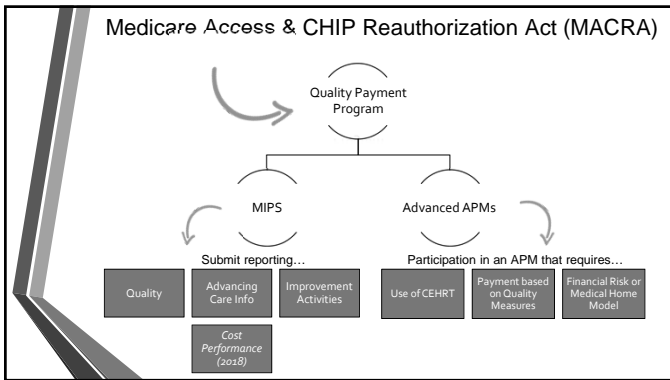
The Final Rules

Meaningful Use Rules
[Stage 1 Final Rule](#)
[Stage 2 Final Rule](#)
[Stage 3 and Modifications to Meaningful Use 2015 – 2017](#)
[2016 - 2018 OPPS Changes to Modified Stage 2 and Stage 3](#)




 Certification Final Rule
[2014 Standards and Certification Final Rule](#)
[2015 Standards and Certification Final Rule](#)

Merit Based Incentive Payment System (MIPS) Review






Who is impacted?

Eligible Clinicians (EC) who bill Medicare Part B services must participate in MIPS.

<p>2017</p> <ul style="list-style-type: none"> Physicians Nurse Practitioners Physician Assistants Certified Registered Nurse Anesthetists Clinical Nurse Specialists 	<p>2019</p> <p>Other allied health professionals may be included (Examples: Social Worker, Dietician, Audiologist)</p>	<p>Clarification</p> <p>For Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC).</p> <p>Eligible clinicians billing under the RHC or FQHC payment methodologies are not subject to the MIPS payment adjustment.</p> <p>However, Eligible Clinicians in an RHC or FQHC billing under the Physician Fee Schedule (PFS) are required to participate in MIPS and are subject to a payment adjustment. Unless they qualify for the low-volume threshold exclusion.</p>
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Exclusions from MIPS

 Low threshold	 Newly enrolled ECs	 Qualified or partially qualified APM participant
During the performance year the EC has Medicare Part-B Billing Charges lower than \$30,000 OR provides care to 100 or fewer Part-B Medicare beneficiaries	New to PECOS and have never billed for Medicare Services	Based on the ECs claims from an Advanced APM entity

MIPS Reporting

You can report to MIPS as a group or as a single provider.

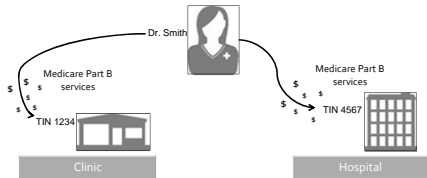


Strategic Considerations

- If you submit as a group for 1 category, you must submit as a group for all other categories. (e.g. Quality Group reporting via CMS Web Interface)
- The reporting mechanism must be the same per category. (e.g. registry vs HER Quality submissions)

MIPS Reporting Example


- Dr. Smith works at a clinic and also provides services at a hospital
- The clinic and the hospital each have a different Tax ID Number




MIPS Reporting Example

- Dr. Smith works at a clinic and also provides services at a hospital
- The clinic and the hospital each have a different Tax ID Number

TIN 1234




Clinic - "individual" reporting




Dr. Smith

She must meet all MIPS requirements and report her data individually to CMS for all services provided under TIN 1234.

TIN 4567



Hospital - "group" reporting



Dr. Smith

Data is aggregated for all EC's billing under the hospital TIN and submitted to CMS.


MIPS Reporting Example

- Dr. Smith works at a clinic and also provides services at a hospital
- The clinic and the hospital each have a different Tax ID Number

Medicare Part B services

-4% deduction applied in 2019

TIN 1234




Clinic

Dr. Smith fails to submit MIPS reporting individually in 2017.

Medicare Part B services

0% - 4% increase applied in 2019

TIN 4567



Hospital

Dr. Smith's data is submitted with group reporting for the hospital TIN.

2017 Reporting Options: "Pick your Pace"

No submission	Test Program	Partial/Full Submission	APM Participant
<p>Non-Participant in MIPS</p> <p>Does not report on any measure for at least 90 days</p> <p>Receives a negative 4% payment adjustment in 2019</p> <p>-4%</p>	<p>Testing MIPS</p> <p>Only report one measure in one category</p> <p>Avoids Negative Payment Adjustment</p> <p>**Testing ACI = all base measures</p> <p>0%</p>	<p>Reporting MIPS</p> <p>Either a Full or Partial (90 days or more) reporting period</p> <p>Report all required measures across all categories</p> <p>0% to +4%</p>	<p>Advanced APM Participant</p> <p>Achieves QP status</p> <p>Receives a 5% incentive payment in 2019</p> <p>Achieves Partial QP Status</p> <p>• Can elect to participate or not in MIPS</p> <p>+5%</p>

January 1, 2017 ← Start of performance period

December 31, 2017 → End of performance period

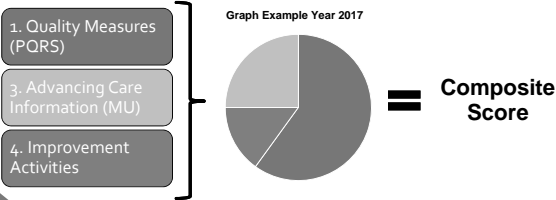
January 1, 2018 ← MIPS Submission open

March 31, 2018 ← MIPS Submission Deadline

"Pick your Pace"

How is MIPS Scored?

Each MIPS EC will receive a composite score based on performance in each of the weighted categories to determine the overall payment for their service. In 2017 the Composite Score is as shown in the graph below (60% Quality, 25% ACI, 15% IA)



Quality Category Scoring

- Weighted at 60% of EC's composite score.
- Providers will submit their Quality data based on the number of providers included in the practice (TIN) as the table below outlines.

TIN	# of Quality Measures to Submit	# of Population Based Measures (claims data)	Total Points to Receive Full 60%
15 or Fewer Eligible Clinicians (ECs)	6 Measures	0 Population based Measures	60 points (10 per measure)
More than 15 Eligible Clinicians	6 Measures	1 Population based Measures	70 points (10 per measure)
Group Submitting via Web Interface	14 measures	1 Population based measures	150 points (10 per measure)

What is the population based measure?

- 30-day All-Cause Hospital Readmission (ACR Measure)**
 - Risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized at a short-stay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge.
 - Only applied to groups of 16 or more that meets the min. case threshold (200 cases)
 - Claims based data used for reporting. **No additional submission required.**

Quality Category Scoring Example

Measure Name	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out	2017 Percent metric	Points toward Quality category
Falls: Screening for Future Fall Risk	6.33 - 17.92	17.93 - 31.98	31.99 - 47.86	47.87 - 63.81	63.82 - 81.04	81.05 - 90.20	90.21 - 98.49	>= 98.50	No	99.1%	10
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	53.85 - 64.74	64.75 - 70.90	70.91 - 86.68	86.69 - 89.31	89.32 - 92.90	92.91 - 96.54	96.55 - 98.67	>= 98.68	No	95.1%	8
Diabetes: Medical Attention for Nephropathy	66.67 - 72.91	72.92 - 78.12	78.13 - 82.26	82.27 - 86.12	86.13 - 89.95	89.96 - 93.32	93.33 - 96.63	>= 96.64	No	85.3%	6
Diabetes: Foot Exam	5.31 - 10.90	10.91 - 19.99	20.00 - 29.26	29.27 - 38.77	38.78 - 50.09	50.10 - 62.60	62.61 - 76.16	>= 76.17	No	51.4%	8
Diabetes: Hemoglobin A1c Poor Control	54.67 - 35.91	35.90 - 25.63	25.62 - 19.34	19.33 - 14.15	14.14 - 9.10	9.09 - 3.34	3.33 - 0.01	0	No	41.7%	3
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	72.59 - 81.59	81.60 - 86.68	86.69 - 90.15	90.16 - 92.64	92.65 - 94.67	94.68 - 96.58	96.59 - 98.51	>= 98.52	No	50.2%	3

Quality Category Reporting Options

- CMS has over **270** measures available which can be reported via other methods
<https://app.cms.gov/measures/quality>
- Consider costs of selected reporting method.
- Analyze provider mix and specialties to ensure optimal reporting for those venues.

Group Reporting

- Qualified Clinical Data Registry (CCDR)
- Qualified Registry
- CMS Web Interface (groups of 25 or more requires pre-registration by June 30, 2017)
- CAHPS for MIPS (Group Only, requires pre-registration, counts as 1 high-priority quality measures)
- EHR Vendor
- Administrative Claims (No submission required and used only for Population measures)

Individual Reporting

- Claims
- Qualified Clinical Data Registry (CCDR)
- Qualified Registry
- EHR Vendor
- Administrative Claims (No submission required and used only for Population measures)

Advancing Care Information (ACI) Scoring

- Weighted at 25% of MIPS composite score in 2017.
- Must utilize CEHRT to report for ACI (2014, 2015 or combination of CEHRT is acceptable in 2017).
- Must reach a total of **100 points** out of a potential **155 points possible** to receive the full 25% credit for composite score.
 - Four required measures in 2017 (Base measures) is using 2014 CEHRT level. 5 base measures required if using 2015 CEHRT level.
 - All other measures factor into EC's performance score points.
- In 2017 CMS will award a bonus score for improvement activities that utilize CEHRT and for reporting to public health or clinical data registries (bonus does not including Immunization submissions).

Scoring for ACI Performance Score

Base Measures
(50 points)

→

Performance Measures
(90 points)

→

Bonus Measures
(15 points)

****All or Nothing****
You must satisfy all base measure requirements to receive any points for the ACI MIPS component.

Required Base Measures	Requirement
✓ Security Risk Assessment	Completed Annually
✓ eRx	1 in Numerator
✓ Provide Patient Access (VD1s)	1 in Numerator
✓ Health Information Exchange (IxC)	1 in Numerator
✓ Request/Accept Patient Care Record (2015 CEHRT)	1 in Numerator

Performance Score Measures	Performance Points Possible
Provide Patient Access (VD1s)	20 Points
View, Download, or Transmit (VD1s)	20 Points
Patient Specific Education	10 Points
Secure Messaging	10 Points
Health Information Exchange (IxC)	20 Points
Medication Reconciliation	10 Points
Immunization Registry	10 Points

Bonus Measures	Bonus Points Possible
Additional Public Health Measures	5 Points
Report improvement activities using CEHRT	10 Points

****Active engagement still counts for public health submission.**

Improvement Activities (IAs)

- Weighted at 15% of composite score in 2017.
- Designed to reward ECs for conducting activities focused on care coordination, beneficiary engagement and patient safety.
- Over 90 clinical practice improvement activities in two categories (not all require CEHRT).
- Must reach 40 points to receive full 15% credit for composite score.
- Medium Category (10 Points)
 - Example: Participate in a QCDR, clinical data registries, or other registries
- High Category (20 Points)
 - Example: Provide 24/7 access to MIPS EC's for emergent care.
 - **Practices of less than 15 EC's have the point weight from medium and high category activities doubled.
- Some programs you may already be participating in are worth points in this MIPS component.

Current Practice Improvement Models	Points Awarded
Patient Centered Medical Home (PCMH)	40 points
Alternative Payment Model (APM)	20 points

Improvement Activities worth Bonus Points for ACI

- Activities that utilize CEHRT are worth bonus points for ACI.
- (See full list of activities [Here](#))

ACTIVITY NAME	ACI	ACTIVITY
	STATUS	WEIGHTING
Anticoagulant management improvements	Yes	High
Chronic care and preventative care management for empanelled patients	Yes	Medium
Electronic Health Record Enhancements for BH data capture	Yes	Medium
Engagement of patients, family and caregivers in developing a plan of care	Yes	Medium
Engagement of patients through implementation of improvements in patient portal	Yes	Medium
Glycemic management services	Yes	High
Implementation of documentation improvements for practice/process improvements	Yes	Medium
Implementation of episodic care management practice improvements	Yes	Medium
Implementation of integrated PCMH model	Yes	High
Implementation of medication management practice improvements	Yes	Medium
Implementation of methodologies for improvements in longitudinal care management for high risk patients	Yes	Medium
Implementation of practices/processes for developing regular individual care plans	Yes	Medium
Implementation of use of specialist reports back to referring clinician or group to close referral loop	Yes	Medium
Improved practices that disseminate appropriate self-management materials	Yes	Medium
Operating a QCDR to standardize processes for screening	Yes	Medium
Practice improvements for bilateral exchange of patient information	Yes	Medium
Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record	Yes	High
Use of certified EHR to capture patient reported outcomes	Yes	Medium
Use of decision support and standardized treatment protocols	Yes	Medium

Proposed Changes to the Merit Based Incentive Payment System (MIPS) in 2018.

QPP Proposed Rule

- CMS proposed rule changes to MIPS in 2018:
 - 2018 would be another flex year option for CEHRT level allowing EC's to attest using 2014 or 2015 CEHRT level.
 - ACI is given a 90 day reporting period, meaning CEHRT can be achieved after January 1st.
 - 2015 edition CEHRT requires API access at every instance for the provide patient access (VDT2) within the performance period.
 - Proposed that EC's would receive 10 bonus points for attesting using 2015 CEHRT for ACI in 2018.

Quality Category

- 2017 Final Rule
 1. Reduction of Final Score Percentage to 50%
 2. Sets the 2018 Data Completeness Criteria at 60%
 3. First Year of Performance which does not include an Improvement Bonus
 4. Must submit Category using one Submission Mechanism (unless also reporting CAH)
- 2018 Proposed Rule
 1. Proposes to retain a 60% Quality Category of the Final Score
 2. Proposes to reduce the 2018 Data Completeness to 50%
 3. Improvement Bonus Calculation is proposed for the Quality Category
 4. Proposes multiple submission mechanisms within category

Cost Category

- 2017 Final Rule
 1. The 2018 Performance Period has cost at 10% of the overall Final Score
 2. There are 10 Episode Base Measures along with Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC)
 3. All ECs (including Facility-Based ECs) did not score Cost in 2017
- 2018 Proposed Rule
 1. 2018 Performance Period Cost category is reweighted to 0% (Quality 60%)
 2. CMS is proposing to remove the projected Cost Category Episode Measures
 3. Facility Based ECs (75% or more of their services are in a hospital setting) can elect cost measured based on their hospital performance

Improvement Activities Category

- 2017 Final Rule
 1. A list of 93 Activities that an EC or group of ECs can select from
 2. One EC needs to participate in the Activity to receive credit
 3. At least one practice site needs to be certified as PCMH for the group to receive full credit for the IA Category

- 2018 Proposed Rule
 1. CMS is proposing updates to some of the 93 measures, and proposing more activities that can be used in 2018
 2. CMS is proposing that at least 50% need to participate in the activity to receive credit
 3. At least 50% of the practice sites within the TIN must be recognized as PCMH in order to receive PCMH credit for the IA Category

Advancing Care Information

- 2017 Final Rule
 1. Offers 10 points for participation in an Immunizations Registry
 2. Performance Year 2019 is a Full Year performance
 3. Did not include measure exclusions for eRx, HIE, and Summary of Care

- 2018 Proposed Rule
 1. For those ECs who are not able to participate in an Immunizations Registry
 1. CMS proposes ECs can perform 2 other Public Health Objectives (0 or 5% each) up to 10%
 2. If the EC does a third Public Health Objective they are still eligible to receive the 5% bonus
 2. CMS proposes a 90 day Performance Period in 2019
 3. Proposes to include exclusions and backdates for 2017 use
