



MACRA / MIPS / QPP

*Maximizing Your Participation
and Reimbursement*

Disclaimer

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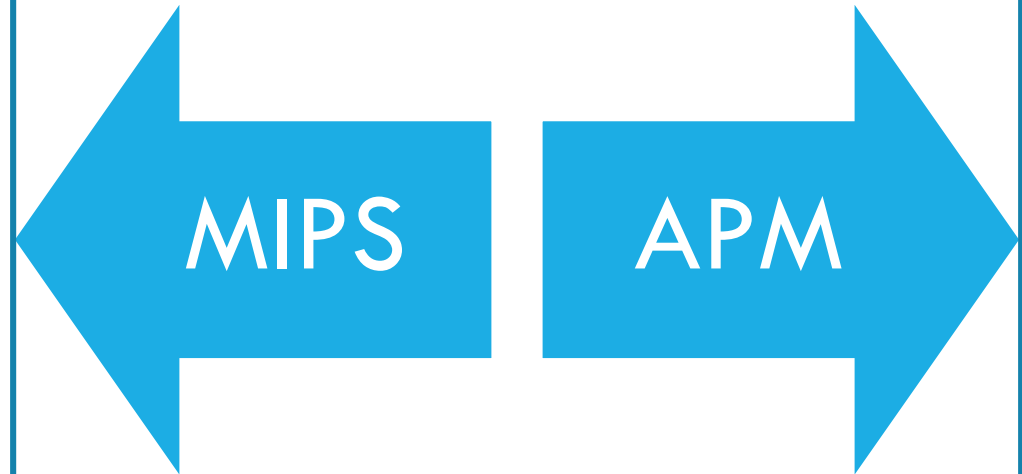
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MACRA Legislation

MACRA

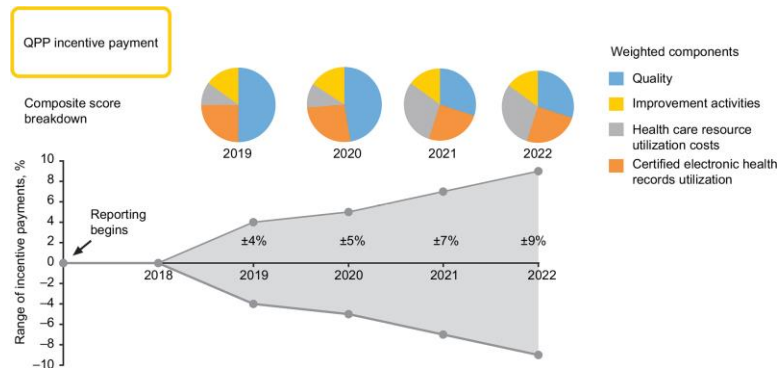
Established two
Medicare paths
for physicians



MACRA is a Two-Track System

MIPS

- Traditional Part B Medical Payment Methodology
- Performance Based Payment Adjustment (up or down)
- There are points to avoid negative adjust
- There are points to earn exceptional performance threshold



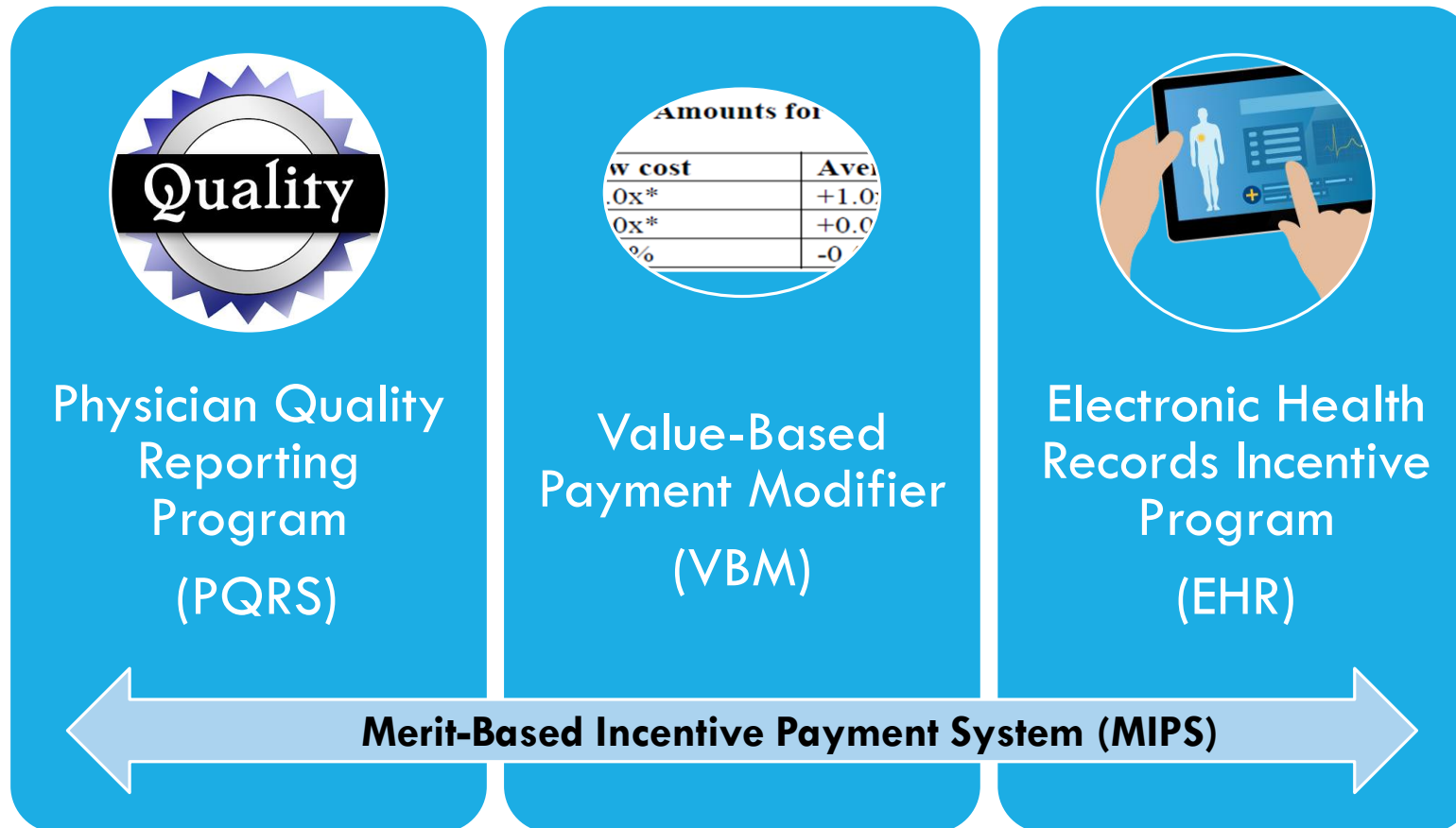
Advanced Alternative Payment Models (APM or AAPM)

- Shared Risk Based Payment Methodology
- Incentive Payment for Participating in Innovative Payment Models

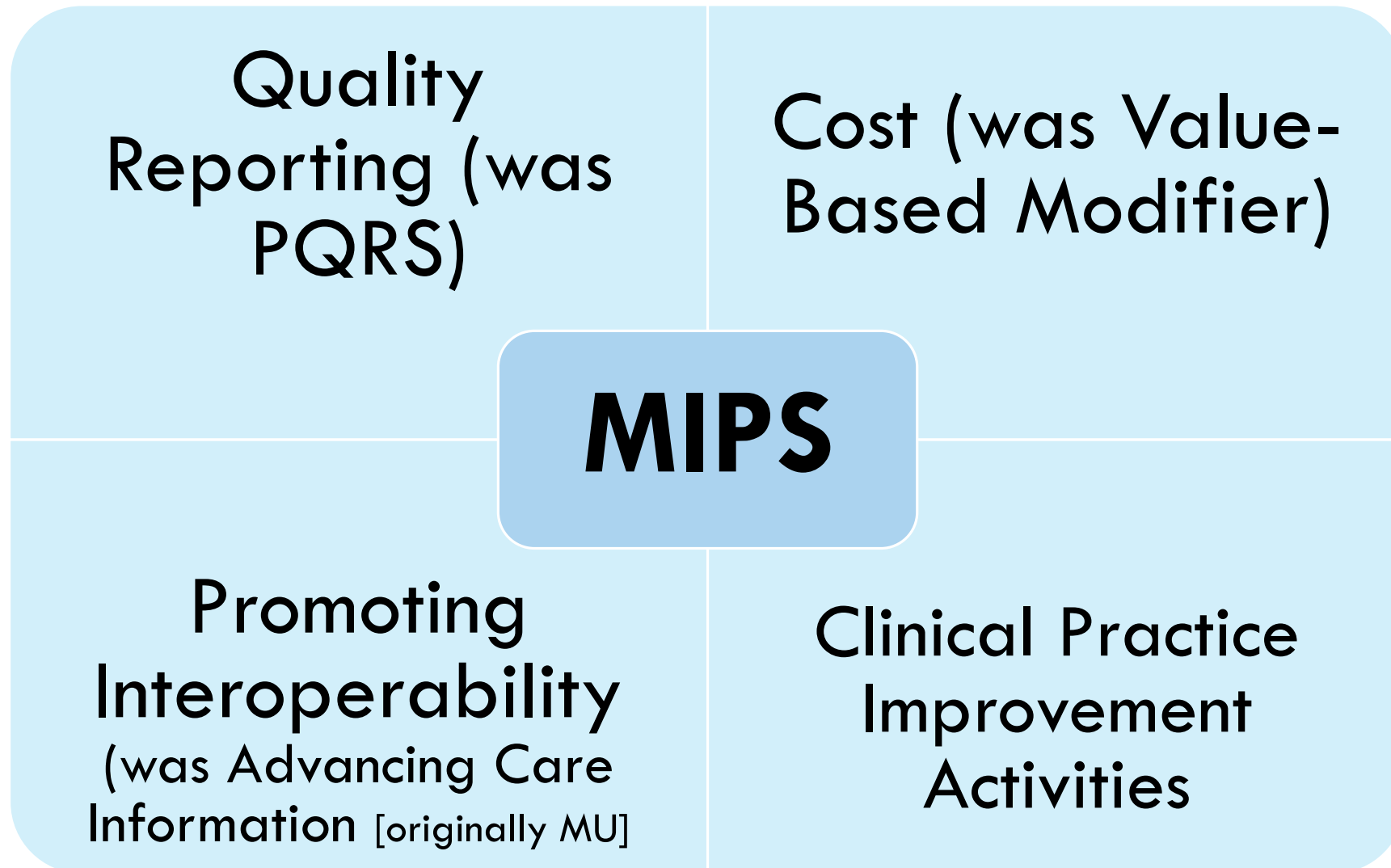


MACRA Legislation

MACRA streamlined these programs into the
Quality Payment Program (QPP)



MIPS Components



MIPS Performance Category Weights

(Over time, the cost category will gradually become larger and the quality category will become smaller)

2017

- Quality = 60%
- ACI = 25%
- CPIA = 15%

2018

- Quality = 50%
- ACI = 25%
- CPIA = 15%
- Cost = 10%

2019

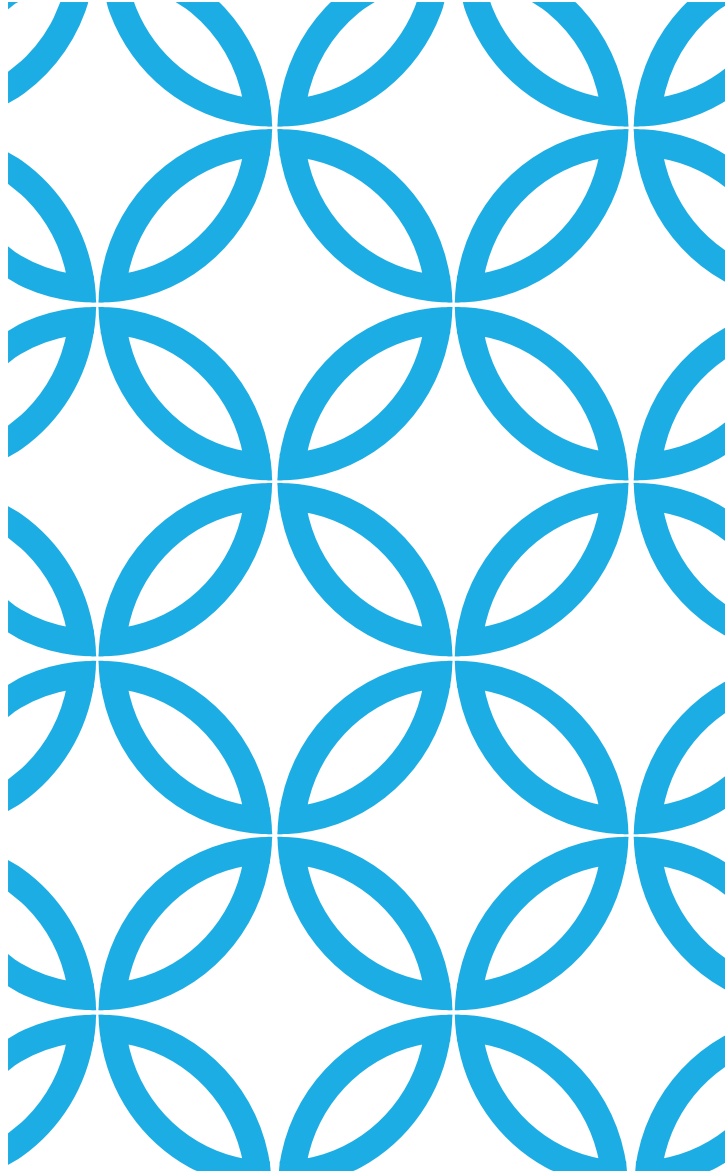
- Quality = 30%
- ACI = 25%
- CPIA = 15%
- Cost = 30%

2020

- Quality = 45%
- Promoting Interoperability = 25%
- Improvement Activities = 15%
- Cost = 15%

Historically

- ❑ Eligible Professionals (EP) and Clinicians (EC) have been added
- ❑ Low Volume Thresholds have been established
- ❑ Opt-In option has been added
- ❑ Exemptions have been added
- ❑ Weighting of Performance Categories have varied from original rule
 - ❑ Quality
 - ❑ Cost



MIPS 2020

Reporting Requirements

Quality

Promoting Interoperability

Improvement Activities

Cost

Eligibility

*Check your
eligibility at:
qpp.cms.gov*

Low Volume Threshold

\leq \$90,000 in Part B Charges **or**

\leq 200 Part B Patients **or**

\leq 200 covered professional services

A Provider Who Is Not Automatically Eligible Can
OPT-IN

When Should You Opt In?

- ❖ When you are prepared
- ❖ When you would like to track and report your information
- ❖ When it makes financial sense
 - ❖ Below threshold for patients seen but above threshold for Part B charges
 - ❖ Planning on taking on more Medicare patients in 2022

When **Not** to Opt In

- ❖ When you are a new physician just starting
- ❖ When you are going through major changes like a new EHR, new staff, or retirement is pending
- ❖ When it does not make financial sense
 - ❖ You plan on reducing your Medicare patients
 - ❖ You see very few Medicare patients
- ❖ You can still track your performance and not report
 - ❖ Helps you prepare to report in the future
 - ❖ Improves patient care

Reporting Thresholds

- **Performance Threshold**
 - Increased threshold to 45 points (30 in 2019)
 - Will be 60 points in 2021
 - Increased exceptional performance threshold to 85 points for both 2020 and 2021
- **Complex patient bonus**
 - Final score increased up to 5 points based on patients' medical complexity and social risk
 - CMS calculates medical complexity using HCC scores
 - Social risk is based on dual eligibility for Medicare and Medicaid/MediCal

Quality = 45%

Promoting Interoperability = 25%

Improvement Activities = 15%

Cost = 15%

Category Weights for 2020

Quality

- Removed 42 measures
- Revised 83 measures
- Added 4 measures
- Increased Topped-out measures to 61
- Increased Data Completeness threshold to 70%

What is Data Completeness?

Per CMS: “If quality data is submitted selectively such that the data are unrepresentative of a MIPS eligible clinician or group’s performance, any such data would not be true, accurate, or complete.”

This means that if you are able to submit more than 70% of eligible data in MIPS 2020, you must do so.



Promoting Interoperability

- ❑ Removed one (1) Bonus Measure
 - ❑ Removed Verify Opioid Treatment Agreement Measure

- ❑ Kept Query of Prescription Drug Monitoring Program (PDMP) as optional measure

- ❑ Changed Definition of Hospital-based group
 - ❑ For groups with hospital-based clinicians, at least 75% of the individual clinicians in a group must be considered hospital-based for group to be considered hospital-based
 - ❑ Up from 25% in 2019

- ❑ Exempt from reporting PI if hospital-based
 - ❑ PI = 0%
 - ❑ Quality = 60%

Improvement Activities

- ❑ Increased participation threshold for group reporting
 - ❑ Groups earn credit for IA if at least 50% of clinicians fulfill the activity during any continuous 90-day period
 - ❑ The 50% fulfilling the activity do not have to fulfill the activity during the same 90-days period
- ❑ Changes to list of activities
 - ❑ Added 2 improvement activities
 - ❑ Modified 7 activities
 - ❑ Removed 15 activities
 - ❑ Added Covid-19 measure – clinical trial participation
 - ❑ High-weighted, so get full credit for the IA Category if participating

Cost

- Automatically calculated from claims data
- Two fundamental measures – both were revised
 - Total per Capital Cost (TPCC)
 - Medicare Spending per Beneficiary (MSPB)
- Additional measures
 - 8 Episode measures in 2019
 - 18 Episode measures in 2020

CMS only includes measures for which the providers have attributed patients

New Episode- Based Measures

1. Acute Kidney Injury Requiring New Inpatient Dialysis
2. Elective Primary Hip Arthroplasty
3. Femoral or Inguinal Hernia Repair
4. Hemodialysis Access Creation
5. Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
6. Lower Gastrointestinal Hemorrhage
7. Lumbar Spine Fusion for Degenerative Disease; 1 - 3 levels
8. Lumpectomy Partial Mastectomy, Simple Mastectomy
9. Non-Emergent Coronary Artery Bypass Graft (CABG)
10. Renal or Ureteral Stone Surgical Treatment

QUALITY



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graph TD; A[QUALITY] --> B[PROMOTING INTEROPERABILITY]; B --> C[IMPROVEMENT ACTIVITIES]; C --> D[COST]
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PROMOTING INTEROPERABILITY

IMPROVEMENT ACTIVITIES

COST

This Is What You Report

Quality

The quality measures included are related to patient outcomes, appropriate use of medical resources, patient safety, efficiency, patient experience, and care coordination

- Must report 6 quality measures
 - One (1) outcome measure or high priority measure if it is not possible to report on a outcome measure
- Must report performance or exclusion/exception data for at least 70% of patients that are eligible for the measure's denominator
- Quality measures may be submitted via multiple submission types. Measures that are submitted via multiple collection types will be evaluated, and the collection type with the greatest measure score will be used.

Promoting Interoperability

This performance category includes measures that exhibit how well clinicians use their certified EHR technology, as it relates to interoperability and health information exchange.

- Eligible providers will be required to meet the following these objectives
 - Electronic Prescribing
 - Health Information Exchange
 - Provider to Patient Exchange
 - Public Health and Clinical Data Exchange
- No points are given for completing the Security Risk Analysis measure, however the measure is required and must be completed to earn points in this category
- Groups qualify for automatic reweighting of this performance category when 75% of the clinicians in the group are hospital-based – one can apply for other exemptions for this category as well

Improvement Activities

The measures in this category focus on patient safety, care coordination, beneficiary engagement, population management and health equity.

- Most clinicians must participate in and submit two to four improvement activities to receive the maximum score of 40 points in this category
 - Each improvement activity is classified as either medium-weight (10 points) or high-weighted (20 points)
 - Clinicians, groups, and virtual groups with certain special statuses (small practice, rural, HPSA, or non-patient facing) earn two times the points for each activity
- Reporting is by attestation

Cost

This category is made up of twelve measures, Total Per Capital Cost Measure, Medicare Spending Per Beneficiary Clinical measure, and 18 episode-based cost measures. All measures are derived from submitted Medicare Part A & B claims.

- The Medicare Spending per Beneficiary Measure has been revised. The updated name is Medicare Spending per Beneficiary Clinician measure. The attribution methodology has been refined for medical and surgical episodes. There are service exclusions available for costs that are unlikely to be influenced by clinicians
- The Total per Capita Cost measure has been revised. The attribution methodology has been refined for identifying primary care relationships. Specialty exclusions are available for clinicians who do not provide primary care services. Risk adjustment has been refined to account for changes in patient health status during the year.



Know What Categories You Need To Report

Do you qualify
for exemptions?

Do You Need To Report Promoting Interoperability?

- Clinicians such as nurse practitioners, therapists, psychologists, and non-patient facing providers are automatically exempt
- There are also some providers that can apply for an exemption
 - Small practices of 15 or fewer EC's
 - Decertified EHR
 - Extreme and uncontrollable circumstances
 - Apply here: www.qpp.cms.gov

Will You Be Eligible for the Cost Category?

- There are minimum thresholds for every measure
 - TPCC – 20 patients
 - MSPB – 35 episodes
 - Episode-based measures – 10 or 20
- There is no reporting necessary. If you do not qualify for any of the measures you will be automatically excluded

2020 Exceptions & Exemptions

- Extreme and Uncontrollable Circumstances Exception
 - Allows you to request reweighting for any or all performance categories if you encounter an extreme and uncontrollable circumstance or public health emergency, such as COVID-19, that is outside of your control.
- MIPS Promoting Interoperability Performance Category Hardship Exception
 - Allow you to request reweighting specifically for the Promoting Interoperability performance category if you qualify for one of the reasons.

Extreme & Uncontrollable Circumstances

Extreme and uncontrollable circumstances are defined as rare events entirely outside of your control and the control of the facility in which you practice

- Cause you to be unable to collect information necessary to submit for a MIPS performance category
- Cause you to be unable to submit information that would be used to score a MIPS performance category for an extended period of time (for example, if you were unable to collect data for the Quality performance category for 3 months), **and/or**
- Impact your normal processes, affecting your performance on cost measures and other administrative claims measures
- *You must apply for the exception*
 - *Clinicians*
 - *Groups*
 - *Virtual Groups*

When is it Automatically Applied?

- MIPS eligible clinicians who are located in a CMS designated region that has been affected by an extreme and uncontrollable event (such as FEMA designated major disaster), during the 2020 MIPS performance period, receive this exception automatically
- The policy does not apply to groups or virtual group participation
- EC's identified as affected will have all four MIPS performance categories re-weighted to 0% of their final score, unless they submit data for two or more performance categories
 - If you submit data on two or more categories, you'll receive a final score based on your performance in these categories

Promoting Interoperability Performance Hardship Exception

Certified Electronic Health Record Technology (CEHRT) is required for participation in this category. You may qualify for a re-weighting of the PI performance category to 0% if you meet the criteria for exception

- You are a small practice (<15 clinicians)
- You have decertified EHR technology
- You have insufficient internet connectivity
- You face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress, or vendor issues
- You lack control over the availability of CEHRT
 - This on does not qualify you for re-weighting

How do you apply (for both exceptions)

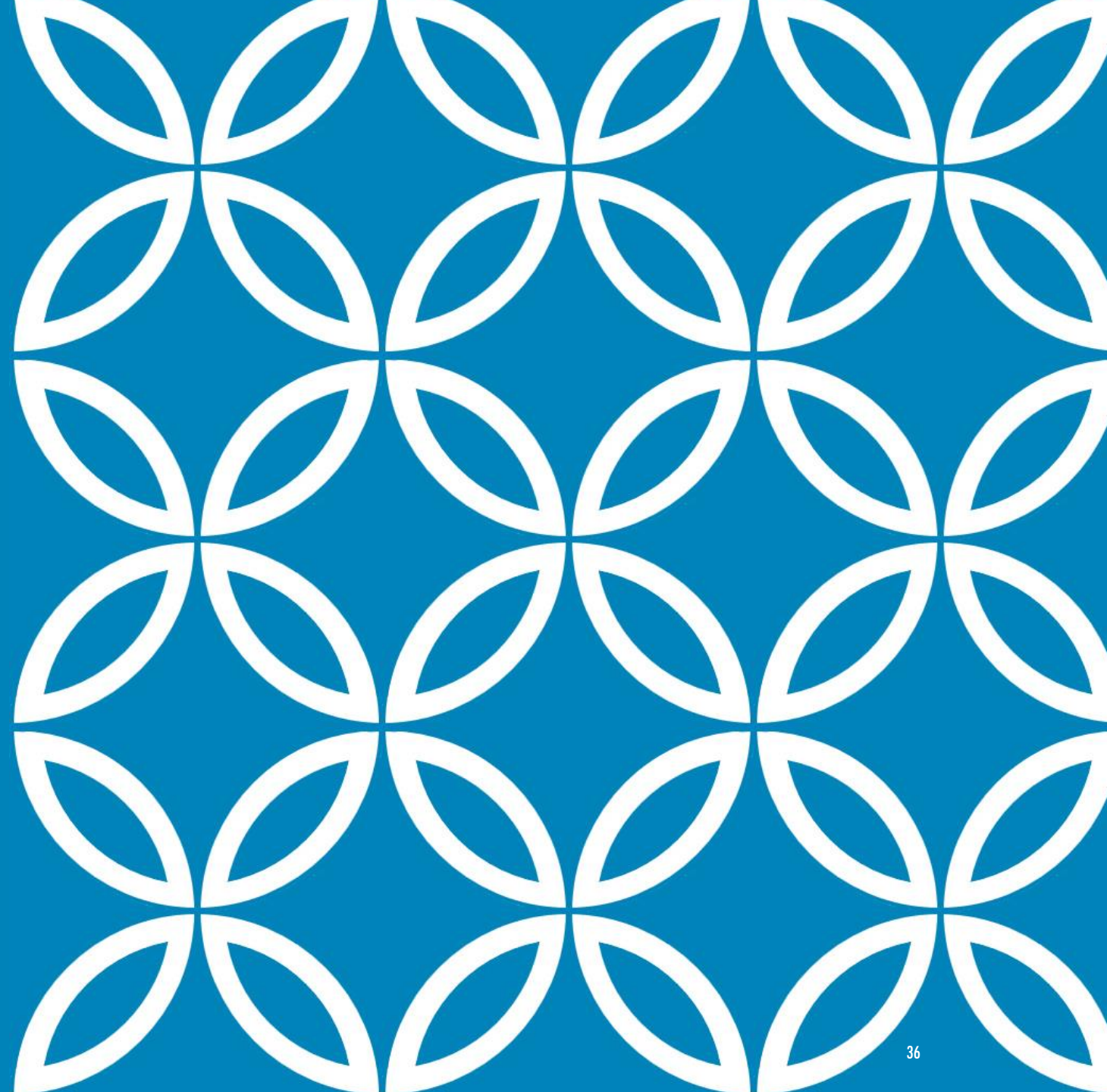
- You need a HCQIS Access Roles and Profile (HARP) account
 - Refer to the **Register for a HARP Account** document in the [QPP Access User Guide](#)
 - Sign into QPP and select 'Exception Application'; Select the exception application you wish
- You will be notified by email if your request was approved or denied
 - Check status of your application by signing into QPP
- If approved, this will also be added to your eligibility profile in the [QPP Participation Status lookup tool](#).
 - May not appear in the lookup tool until the submission window is open in 2021

If Approved:

- **Extreme & Uncontrollable Circumstances**
 - You do not have to report for the requested MIPS performance category or categories, and those categories will be re-weighted
- **Promoting Interoperability Hardship**
 - You do not have to report PI performance category and the category will be re-weighted to 0% of your final score.
 - The 25% weight of this category will be redistributed to another performance category (or categories)

MIPS Tips & Tricks

Track Your Data
Throughout the Year!



Focus on Performance Improvement by Attacking Gaps in Care



Providers – see if someone is not carrying their weight



Patients – see if there is a patient type that is causing your scores to suffer



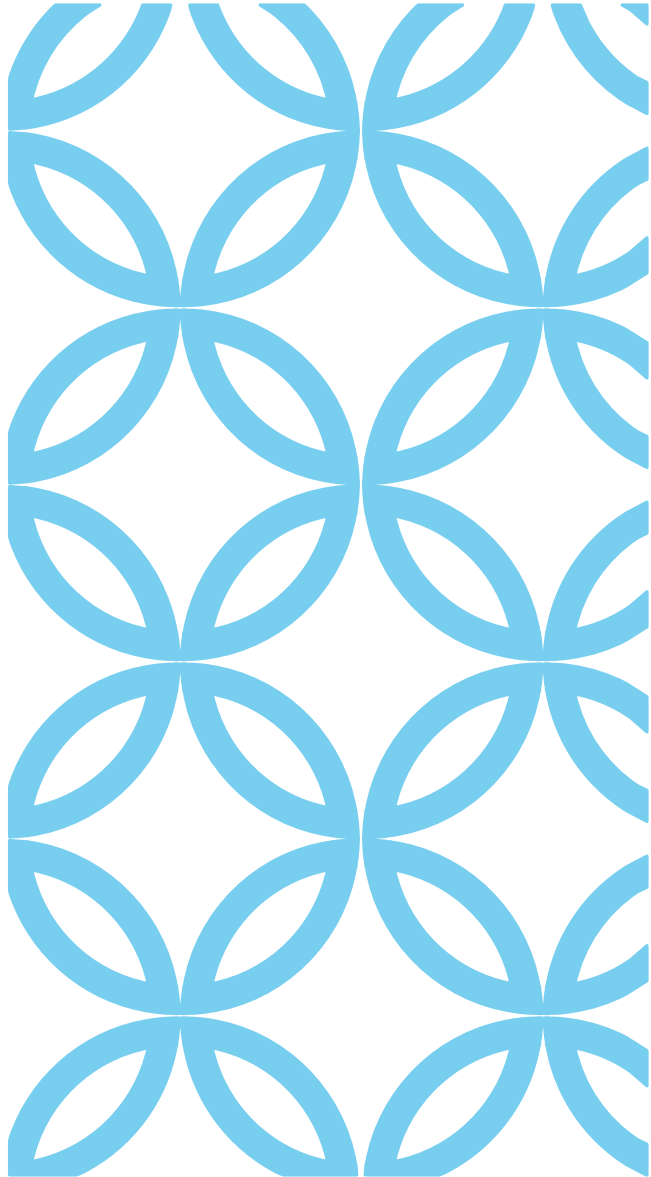
Measures - see what measure may have been overlooked

Track More Than 6 Quality Measures

- Choose 8-10 measures and watch their performance
- Start eliminating measures through the year to optimize your time

Optimize Promoting Interoperability Scoring

- Choose your BEST 90 days
- Review your past performance reports for areas of improvement – and perhaps process change
 - Support Electronic Referral Loops by Sending Health Information
 - Support Electronic Referral Loops by Receiving and Incorporating Health Information
 - Provide Patients Electronic Access to Their Health Information



2021

Proposed Rule (Changes)

A Few Of The Changes

Policy Area	CY 2020 Policy	CY 2021 Proposed
MIPS Value Pathways	<u>MVP Implementation Timelines:</u> MVPS will be a participation framework beginning with the 2021 performance period.	<u>MVP Implementation Timeline:</u> MVPs will not be available for MIPS reporting until the 2022 performance period, or later
Performance Category Weights	<u>No change from CY 2019</u> Quality = 45% Cost = 15% Promoting Interoperability = 25% Improvement Activities = 15%	<u>Proposing for 2021:</u> Quality = 40% Cost = 20% Promoting Interoperability = 25% Improvement Activities = 15%
Quality Performance Collection Types	<u>Available for Groups & Virtual Groups:</u> <ul style="list-style-type: none"> • CMS Web Interface Measures • eCQMs • Medicare Part B Claims Measures • MIPS Clinical Quality Measures • QCDR Measures 	<u>For Groups & Virtual Groups</u> Proposing to remove CMS Web Interface as submission type

Proposed Changes

Policy Area	CY 2020 Policy	CY 2021 Proposed
Quality Measures		Proposing a total of 206 quality measures for 2021 <ul style="list-style-type: none"> • Substantive changes to 112 existing measures • Changes to specialty sets • Removal of measures from specific specialty sets • Remove of 14 quality measures • 2 new administrative claims outcome quality measures
Improvement Activities	Added 2 new activities Modified 7 existing activities Removed 15 existing activities	<ul style="list-style-type: none"> • Modification of 2 existing Improvement Activities

Proposed Changes

Policy Area	CY 2020 Policy	CY 2021 Proposed
Promoting Interoperability		<ul style="list-style-type: none">▪ Retain the Query of PDMP measure as an optional measure and propose to make it worth 10 bonus points▪ Change the name of the Support Electronic Referral Loops to Receiving and Incorporating Health Information by replacing “incorporating” with “reconciling”▪ Add an optional Health Information Exchange (HIE) bi-directional exchange measure▪ Continue automatic reweighting policy for NPP QHP

Proposed Changes

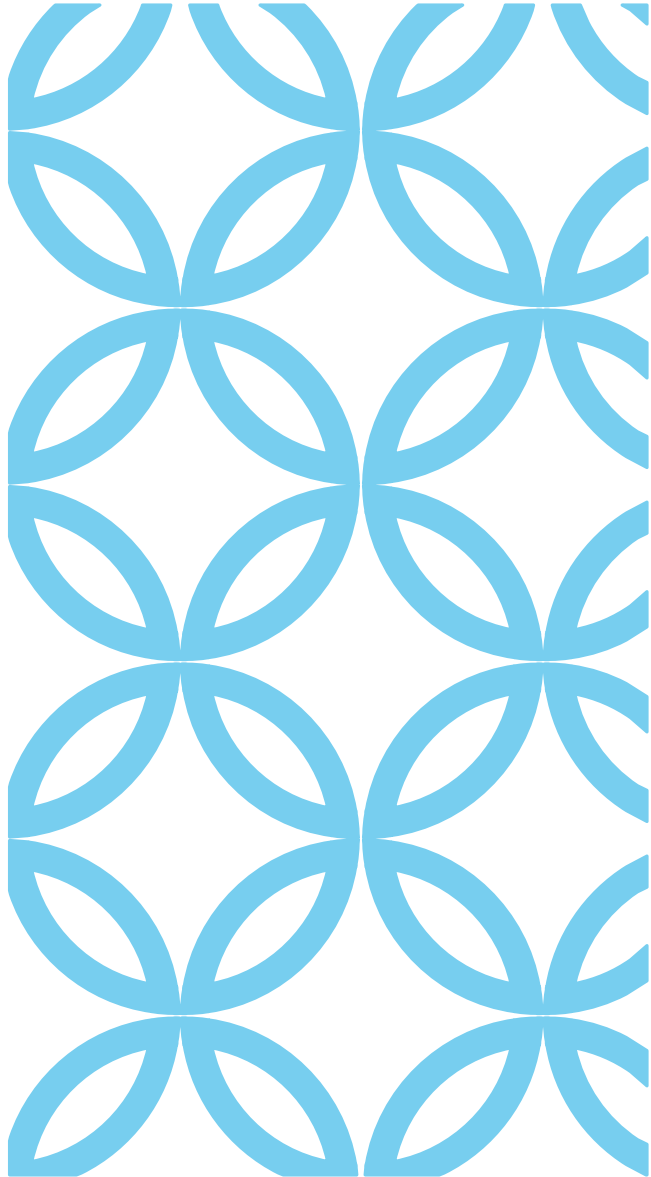
Policy Area	CY 2020 Policy	CY 2021 Proposed
Cost Performance Category	Measures: <ul style="list-style-type: none"> • TPCC • MSPB-C • 8 existing episode-based measures • 10 new episode-based measures 	Measures (previously established) <ul style="list-style-type: none"> • TPCC measure • MSPB Clinical measure (no change) • 18 existing episode-based cost measures Updates to measures: <ul style="list-style-type: none"> • Adding telehealth services directly applicable to existing episode-based cost measures and TPCC measure • Updated specifications available for review on the MACRA feedback page

Proposed Changes

Policy Area	CY 2020 Policy	CY 2021 Proposed
<p>Performance Threshold/ Additional Performance Threshold/ Payment Adjustment</p>	<p><i>For the 2020 performance period (2022 payment year):</i></p> <ul style="list-style-type: none"> • Performance Threshold is set at 45 points • Additional performance threshold is set at 85 points • Maximum negative payment adjustment is - 9% • Positive payment adjustments can be up to 9%, but are multiplied by a scaling factor to achieve budget neutrality, which could result in an adjustment above or below 9% <p><i>For the 2021 performance period:</i></p> <ul style="list-style-type: none"> • Performance threshold is set at 60 points • Additional performance threshold is set at 85 points for exceptional performance 	<p><i>For the 2021 performance period (2023 payment):</i></p> <ul style="list-style-type: none"> • Proposed to set the Performance Threshold at 50 points. <p><i>No proposed changes to the additional performance threshold of 85 points for exceptional performance</i></p>

Getting Ready for 2021

- Review Quality Measures when they are finalized
 - All measures are available on QPP website: www.qpp.cms.gov
- Review Past Performance Reports to assess areas of low performance and consider changes to be made that will lead to better performance
 - Review Numerator/Denominator relationships when appropriate
- Review exemptions/exceptions annually
- Review Improvement Activities that you can be successful with



Thanks for Your Attention —
Questions ?



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