MIPS in 2017

Jeffrey D. Lehrman, DPM, FASPS, FACFAS, MAPWCA

APMA Coding Committee
APMA MACRA Task Force
Expert Panelist, Codingline
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Quality Payment Payment Program

MACRA

SGR

MIPS

APM
MIPS Score

- Highest total of 100

- EPs will receive either a positive or negative payment adjustment to Medicare part B fee schedule based on MIPS score

- Podiatrists will report through MIPS in 2017 unless they meet one of the exclusions
MIPS Adjustments

2019: -4% to +4% (based on 2017 score)
2020: -5% to +5% (based on 2018 score)
2021: -7% to +7% (based on 2019 score)
2022: -9% to +9% (based on 2020 score)
MIPS Year 1

- Mostly budget neutral
- Penalty no more than 4%
- Most positive adjustments no more than 4%
  ...positive moved based on budget neutrality
- “Exceptional Performance” (70?)
Scores Will Be Publically Reported

- Physician Compare
  https://www.medicare.gov/physiciancompare/#

- Yelp

- Employers

- Private Insurance Carriers
MIPS reporting not limited to Medicare patients*

* Except for Quality measures reported via claims
Exempt from MIPS payment adjustment if:

- Newly enrolled in Medicare
- Less than 30K in Medicare charges or less than 100 Medicare patients
- Significantly participating in APM
- Certain Partially Qualifying APM
Two determination period options to meet 2017 low volume threshold:

9/1/2015 - 8/31/2016

or

9/1/2016 - 8/31/2017
Quality Payment Program

Check if you're included in MIPS

Now you can check if a clinician who bills to Medicare will need to submit data to MIPS. Just enter your National Provider Identifier (NPI) number into our tool.

Check Now >
Am I included in MIPS?
To check if you need to submit data to MIPS, enter your 10-digit National Provider Identifier (NPI) number.

If you’re exempt from MIPS with the first review, you won’t need to do anything else for MIPS this year. If you are included in MIPS, you may be exempt with the second review of eligibility determinations at the end of 2017. Learn more about MIPS eligibility.

National Provider Identifier (NPI)

1285721266

Check Now

 Participating in an Alternative Payment Model (APM)? Talk to your Center for Medicare & Medicaid Innovation (CMMI) team or leaders managing your participation. If you need help finding this information, please email us at qpp@cms.hhs.gov or call 1-866-288-8292
Am I included in MIPS?

To check if you need to submit data to MIPS, enter your 10-digit National Provider Identifier (NPI) number.

If you're exempt from MIPS with the first review, you won't need to do anything else for MIPS this year. If you are included in MIPS, you may be exempt with the second review of eligibility determinations at the end of 2017. Learn more about MIPS eligibility.

National Provider Identifier (NPI)

1285721266

Check Now

Included in MIPS

JEFFREY D LEHRMAN, MD must submit data to MIPS by March 2018. This clinician will need to report as an individual or with a group.

What Can I Do Now?

Show Less

Clinician Summary

<table>
<thead>
<tr>
<th>Clinician Name</th>
<th>NPI</th>
<th>Provider Type</th>
<th>Associated TINs</th>
<th>Enrolled in Medicare before Jan 1, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>JEFFREY D LEHRMAN, MD</td>
<td>1285721266</td>
<td>Doctor of Medicine</td>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Practice Details

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
<th>If clinician reports as individual</th>
<th>If clinician reports with group *</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAVID E SAMUEL DPM</td>
<td>1 MEDICAL CENTER BLVD SUITE 301 UPLAND, PA 190133902</td>
<td>Included in MIPS. This clinician has billed Medicare for more than $30,000 and has provided care for more than 100 patients at this practice.</td>
<td>Included in MIPS. This practice has billed Medicare for more than $30,000 and has provided care for more than 100 patients.</td>
</tr>
</tbody>
</table>
MIPS Performance Year 2017

- Quality (Replaces PQRS)  
  - 60%
- Advancing Care Information (Replaces MU)  
  - 25%
- Clinical Practice Improvement Activities  
  - 15%
- Cost (Resource Use)  
  - 0%
MIPS Score Performance Year 2017

- Quality 60%
- ACI 25%
- Clinical Practice Improvement Activities 15%
- Cost 0%
Quality – 60%
MIPS Quality (60%)

- Report 6 Quality measures
  - One must be an outcome measure
  - If outcome measure not available, must report on at least one high priority measure

- All 6 must be reported by the same mechanism
Quality Measures Submission Methods

- **Claims**
  - 50% or more of Medicare Part B patients

- **Registry**
  - 50% or more of all patients

- **EHR**
  - 50% or more of all patients

- **CMS Web Interface (groups of 25+)**

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ALL SIX MUST BE SUBMITTED BY SAME MECHANISM
Quality Measures

Instructions

1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

Note: This tool is only for informational and estimation purposes. You can't use it to submit or attest to measures or activities.
Quality Measures

Instructions

1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
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Quality Measures Submission Methods

- Claims
- Registry
- EHR
- CMS Web Interface (groups of 25+)

ALL SIX MUST BE SUBMITTED BY SAME MECHANISM
QUALITY MEASURES

Claims Reporting

1. Documentation of Current Meds in the Medical Record
2. Diabetes: Hemoglobin A1c (HbA1c) Poor Control - Intermediate Outcome
3. Pain Assessment and Follow-Up
4. Pneumococcal Vaccination Status for Older Adults
5. BMI Screening and Follow Up Plan
6. Influenza Immunization
7. Screening for High Blood Pressure and Follow Up
8. Tobacco Screening and Cessation Intervention
QUALITY MEASURES
Registry Reporting

1. Diabetes: Hemoglobin A1c (HbA1c) Poor Control - Intermediate Outcome
2. Diabetes: Medical Attention for Nephropathy
3. Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurologic Exam
4. Diabetic Foot and Ankle Care, Ulcer Prevention – Examination of Footwear
5. Documentation of Current Meds in the Medical Record
6. Immunizations for Adolescents
QUALITY MEASURES
Registry Reporting cont.

7. Pain Assessment and Follow-Up
8. Pneumococcal Vaccination Status for Older Adults
9. Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up Plan
10. Preventive Care and Screening: Influenza Immunization
11. Screening for High Blood Pressure and Follow Up
12. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
13. Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
QUALITY MEASURES
EHR Reporting

1. Diabetes: Foot Exam
2. Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) – Intermediate Outcome
3. Diabetes: Medical Attention for Nephropathy
4. Documentation of Current Medications in the Medical Record
5. Falls: Screening for Future Fall Risk
6. Pneumococcal Vaccination Status for Older Adults
7. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
8. Preventive Care and Screening: Influenza Immunization

9. Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

10. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Dissection of a Measure

- Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
DENOMINATOR:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439
Patient Screened for Tobacco Use, Identified as a User andReceived Intervention

**Performance Met: CPT II 4004F:**
Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

**Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco**

**Performance Met: CPT II 1036F:**
Current tobacco non-user

OR

**Tobacco Screening not Performed for Medical Reasons**
Append a modifier (1P) to CPT Category II code 4004F to report documented circumstances that appropriately exclude patients from the denominator

**Medical Performance Exclusion: 4004F with 1P:** Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons)

OR

**Tobacco Screening OR Tobacco Cessation Intervention not Performed, Reason Not Otherwise Specified**
Append a reporting modifier (8P) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**Performance Not Met: 4004F with 8P:** Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified
Advancing Care Information (25%)
Advancing Care Information (25%)

- 50% credit just for reporting
- Other 50% depends on performance
- No more clinical decision support rule
- No more CPOE
Total ACI Score

Base Score + Performance Score + Bonus Points

Max ACI Score = 100
ACI Base Score

- Base score: 10 points for reporting a measure
- Base Score: Max 50
- Base Score: Can get 50 points just for reporting numerators/denominators or yes/no for 5 objectives
- Need numerator to be $\geq 1$ for each
ACI Performance Score

- Performance Score: Receive 1-10 points for each measure reported based on performance of that measure
- Performance Score: Max 90 points
ACI Bonus Points

- 5 Bonus Points for reporting to any additional public health or clinical data registry
- 10 Bonus Points for achieving one Improvement Activity via CEHRT
ACI Total Score

- Base Score (50) + Performance Score (90) + Registry Bonus (5) + Improvement Activity via CHERT (10) = up to 155

- If earn 100 or more, get the full 25 ACI score

- If earn less than 100, declines proportionately. It is not all or nothing
Advancing Care Information

In 2017, there are two measure set options for reporting. The option you use to submit your data is based on your electronic health record edition.

- Option 1: Advancing Care Information Objectives and Measures
- Option 2: 2017 Advancing Care Information Transition Objectives and Measures

Need help identifying your electronic health record edition?

Instructions

1. Review the advancing care information measures available. Remember, in order to get credit for advancing care information, you must submit information for the required measures.

2. Download a CSV file of the measures for your records.

Note: This tool is only for informational and estimation purposes. You can’t use it to submit or attest to measures or activities.
MIPS ACI Required 5 Measures

1. Protect Patient Health Information (yes/no) 0 Performance
2. Electronic Prescribing (numerator/denominator) 0 Performance
3. Provide Patient Electronic Access (numerator/denominator)
4. Send Summary of Care (numerator / denominator)
5. Request / Accept Summary of Care (numerator / denominator)
Can submit more than 5 measures (up to 9) for additional credit
Additional ACI Measures

1. View, Download, or Transmit (VDT)
2. Secure Messaging
3. Patient – Generated Health Data
4. Clinical Information Reconciliation
5. Provide Patient-Specific Education
6. Immunization Registry Reporting
7. Syndromic Surveillance Reporting 0 Performance
8. Electronic Case Reporting 0 Performance
9. Public Health Registry Reporting 0 Performance
10. Clinical Data Registry Reporting 0 Performance
Clinical Practice Improvement Activities (15%)
Clinical Practice Improvement Activities (15%)

- List of 92 options

- Medium weight = 10 points

- High weight = 20 points

- Activities double weighted if group of 15 or less or solo

- Score = points / 40
Clinical Practice Improvement Activities (15%)

- Group of more than 15 clinicians:
  Choose 4 medium weight or 2 high weight activities or 1 high weight + 2 medium weight

- Group of 15 or fewer clinicians or solo:
  Choose 2 medium weight or 1 high weight activity(s)
Improvement Activities

In this new performance category for 2017, clinicians are rewarded for care focused on care coordination, beneficiary engagement, and patient safety.

Instructions

1. Review and select activities that best fit your practice.
   - **Most participants**: Attest that you completed up to 4 improvement activities for a minimum of 90 days.
   - **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area**: Attest that you completed up to 2 activities for a minimum of 90 days.
   - **Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model**: You will automatically earn full credit.
   - **Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model**: You will automatically be scored based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, you will be scored based on the requirements of participating in the specific APM you select.

2017 MIPS Performance

- Quality (50%)
- Advancing Care Information (25%)
- Improvement Activities (15%)
Select Improvement Activities

Search All by Keyword:

Search for...

SEARCH

Filter By:

Subcategory Name

Activity Weighting

Showing 92 Activities

- Additional improvements in access as a result of QIN/QIO TA
- Administration of the AHRQ Survey of Patient Safety Culture
- Annual registration in the Prescription Drug Monitoring Program
- Anticoagulant management improvements
- Care coordination agreements that promote improvements in patient tracking across settings
- Care transition documentation practice improvements

Add All Activities

Add

Remove

Download (CSV)
Clear All

2 Activities Added

Implementation of fall screening and assessment programs

Annual registration in the Prescription Drug Monitoring Program
Clinical Practice Improvement Activities (15%)

1. Registration in your state’s prescription drug monitoring program - **Medium**
2. Implement Fall Screening & Assessment Program - **Medium**
3. Provide 24/7 access to clinician who has real-time access to patient’s medical record - **High**
4. Assess patient experience of care through surveys, advisory councils and/or other mechanisms - **Medium**
5. Use decision support and standardized treatment protocols - **Medium**
6. Program to send reports back to referring clinician - **Medium**
7. Collection and follow-up on patient experience and satisfaction data on beneficiary engagement - **High**
8. Collection and use of patient experience and satisfaction data on access - **Medium**
9. Consultation of the Prescription Drug Monitoring program - **High**
10. Engagement of community for health status improvement - **Medium**
11. Engagement of patients, family and caregivers in developing a plan of care - **Medium**
12. Engagement of patients through implementation of improvements in patient portal – **Medium**

13. Implementation of condition-specific chronic disease self-management support programs - **Medium**

14. Implementation of use of specialist reports back to referring clinician or group to close referral loop - **Medium**

15. Improved practices that disseminate appropriate self-management materials - **Medium**
Activity must have been performed for at least 90 consecutive days
First Option: Test the Quality Payment Program.
- Report one quality measure or one clinical practice activity or report ALL required ACI measures
- Avoid negative adjustment
- No bonus
Pick Your Pace!!

- Second Option: Participate for Part of the Calendar Year.
  - Minimum of 90 days
  - Report more than one quality measure or more than one clinical practice improvement activity, or more than 5 measures of ACI
  - Avoid a negative payment adjustment and possibly qualify for a small positive payment adjustment.
Third Option: Full Participation
- 90 days
- 6 Quality Measures
- Full CPIA
- 5 Required ACI Measures plus additional ACI measures
Register for upcoming webinars
View archived recordings
Download PDF versions of each presentation
apma.org/MacraWebinars or apma.org/webinars
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

On April 16, 2015, President Barack Obama signed into law HR 2, Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Two major aspects of this new system are the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

As CMS releases draft and final rules, guidances, and FAQs for implementation of this new system, APMA will continue to advocate for the best interests of its members, while ensuring that members stay informed and on top of new requirements and deadlines that impact their practice and reimbursements.

Additionally, APMA has established a MACRA task force to design educational programs and strategies to help podiatrists maximize their Medicare reimbursement under the program. These members were chosen based on their extensive experience with the intricacies of CMS reimbursement methods, and their individual expertise range from coding policy to alternative payment models and experience with PQRS, EHR Meaningful Use programs, and Value-based modifiers. These members represent a cross-section of various practice settings, geographic locations, and years in practice.

Task force members: Barbara Aung, DPM; Brooke Bisbee, DPM; Mike Cornelison, DPM; Adam Fleischer, DPM; David Freedman, DPM; Mitch Hilsen, DPM; Crystal Holmes, DPM; Scott Hughes, DPM; Jeff Lehman, DPM; Aprajita Nakra, DPM; Dyane Tower, DPM, MS, MPH; Jacob Wynes, DPM; Mark Block, DPM (ex-officio); Michael Borden (American Society of Podiatric Executives [ASPE] observer); and Richard Bloch, JD (ASPE observer).

APMA Resources

Articles
- MIPS Performance Categories: Quality and Clinical Practice Improvement Activities (APMA News, September/October 2016)
- CMS Announces MACRA Implementation Plan (Sept. 8, 2016)
Thank You!!
MIPS in 2017

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Tobacco Screening and Cessation Intervention

Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention – National Quality Strategy Domain: Community / Population Health

2017 OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS ONLY

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

INSTRUCTIONS:
This measure is to be reported once per performance period for patients seen during the performance period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

Measure Reporting:
The listed denominator criteria is used to identify the intended patient population. The numerator quality-data codes included in this specification are used to submit the quality actions allowed by the measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

DENOMINATOR:
All patients aged 18 years and older

DENOMINATOR NOTE: *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for claims-based measures.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
WITHOUT
Telehealth Modifier: GQ, GT

NUMERATOR:
Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user
Performance Met: CPT II 4004F:

Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user.

OR

Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco

Performance Met: CPT II 1036F:

Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

Append a modifier (1P) to CPT Category II code 4004F to report documented circumstances that appropriately exclude patients from the denominator.

Denominator Exception: 4004F with 1P:

Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason).
Resources

- NOTICE OF PROPOSED RULE MAKING Medicare Access and CHIP Reauthorization Act of 2015

- NOTICE OF PROPOSED RULE MAKING Medicare Access and CHIP Reauthorization Act of 2015

- CMS Timeline
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Timeline.PDF