MACRA and MIPS Notes

Due to the lengthy certification process for many vendors, CMS has declared 2017 to be a transition year. The rules for MACRA and MIPS have been relaxed to allow providers to utilize data collected in their 2014 Certified EHR product for their reporting period, so long as their EHR is updated to the new certification by the end of the reporting period (end of year). Further, of the three major areas for MIPS (Quality, Advancing Care Information, and Improvement Activities), the only category where the new certification will matter (for this year) is Advancing Care Information. This means that providers can start/continue data collection immediately, without waiting on the EHR update later this year. This should allow providers to obtain a positive payment adjustment (between 1-4%) for being able to submit at least 90 days of data on the three categories; rather than just a neutral adjustment (0%) or even a penalty.

At this point, all providers that need to submit MIPS data should have received a letter indicating such from the government. If you have not received such a letter, or want to double check your status, you can verify that information with an NPI number at https://qpp.cms.gov/participation-lookup.

How to Tackle the 3 Major Categories of MIPS

Quality (replaces PQRS)
The Quality category will be familiar to people who participated in the old PQRS program. Quality data can be submitted utilizing Claims Based reporting on 6 measures, including an outcome measure. This means each provider will need to select clinically appropriate measures that can be sent using the "Claims" data submission method (see here for a list https://qpp.cms.gov/mips/quality-measures). Once the selection is made, the reporting procedure code should be included as part of the claim submitted for a Medicare encounter. There are currently 74 measures available for claims based reporting.

Take note that while the data Medicare will receive ultimately comes from the Practice Management system as part of billing, the PQRS reporting code should be documented in the EHR as part of the visit. If the PQRS section of the EHR is not active, AntWorks Healthcare can enable that feature to help identify which patient visits qualify for the various quality measures selected by the providers.

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Advancing Care Information (replaces Meaningful Use)
Due to the challenges of certification, CMS has added a new track for reporting this category, the 2017 Advancing Care Information Transition Objectives, which means providers can collect data now using their 2014 Certified EHR version. Also, they will be able to report on all of that collected data regardless of when the EHR is upgraded to a 2015 certified version. They will report this information by performing an attestation via the CMS Quality Payment Program website.

This section is a replacement of the Meaningful Use part of the EHR Incentive Program and has been greatly simplified. For the transition year track, providers will only have to report on 4 measures, but can report on more for a better performance score (there are 7 additional measures). The four primary measures needed to achieve a 50% score for this section are:

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Health Information Exchange.

If a provider had already been participating in the EHR Incentive program and demonstrating Meaningful Use, they will have already been meeting these objectives and can simply continue to fulfill them to the highest levels possible. If a provider is exempt from one these measures (for example, does not refer patients to other care settings and thus does not meet the requirements for the Health Information Exchange), the points awarded for that measure will be shifted to the other measures when the performance score is calculated.

Improvement Activities (new section)
This is a new reporting area where providers must select and report on up to 4 Improvement Activities from 9 subcategories. They will report this information by performing an attestation via the CMS Quality Payment Program website. Providers will simply indicate which activities they have chosen and report “Yes” or “No”.

The goal of this section is to achieve the maximum of 40 points. Providers in a group with less than 15 clinicians can reach that score of 40 points by either selecting 1 High-weighted activity, or 2 Medium-weighted activities. You can see a filterable list of activities at https://qpp.cms.gov/mips/improvement-activities. A simple example of a high-weight activity would be “Engagement of new Medicaid patients and follow-up”, which is intended to ensure patients with Medicaid (including ones that also have Medicare) are seen in a timely manner.

Please note that currently there is not a defined method to track improvement activities in the 2014 Certified EHR. Once providers have selected their activities, they will need to document their use in such a way that can be reported if ever audited. When performing the attestation, you will not need to supply this data; rather, you will simply indicate that it was done.