It’s 2017 and MACRA is Here:
An Overview of How We Got Here and
How to Get Started

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Common Theme

Bi-partisan effort aimed at moving Medicare payment into a system based on outcomes, quality, and efficiencies

- Goal of tying 30% of traditional or fee-for-service Medicare payments to “quality or value” through alternative payment models by the end of 2016 (already achieved); 50% of payments to these models by the end of 2018.
Medicare Access and CHIP Reauthorization Act (MACRA) 
Overview

• Developed in bipartisan, bicameral process over 2+ years
• Supported by over 750 national and state-based physician organizations
• Passed House of Representatives March 26, 2015 - 392-37
• Passed Senate April 14, 2015 – 92-8
• Permanently eliminates the SGR, which has been producing Medicare physician payment cuts annually since 2002 and provides for 5 years of a 0.5% update.
• Implements new payment system that ties reimbursement to performance and offers two payment pathways: Modified fee-for-service model (MIPS) and Advanced Alternative Payment Models (APMs)

Medicare Access and CHIP Reauthorization Act (MACRA) 
Overview

• **MIPS - Merit-Based Incentive Payment System**
  – Consolidates the current quality reporting programs, PQRS, VBPM, Meaningful Use and adds clinical practice improvement activities, into a new program - beginning in 2019, based on 2017 reporting (flexibility for start date and reporting requirements).

• **APMs – “Advanced” Alternative Payment Models**
  – Based on participation in an APM and meeting certain thresholds.
  – Will be exempt from MIPS and will receive a 5% bonus payment for six years.
MACRA Overview (cont.)

• Global Surgical Codes Protected
  – CMS Policy would have transitioned all 10- and 90-day global codes to 0-day
  – Analysis showed that ophthalmology would have been the hardest hit specialty

• Standard of Care Protection Act
• Indefinite Opt-Out for Private Contracting
• EHR’s required to be “interoperable” by 2017

MACRA Improvements vs. Prior Law

<table>
<thead>
<tr>
<th>Then</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Negative Updates for the foreseeable future</td>
<td>• Modest, but positive updates for 5 years, and then again in 2026 and beyond</td>
</tr>
<tr>
<td>• Multiple overlapping, rigid, and sometimes contradictory reporting and penalty programs</td>
<td>• Consolidated Merit-Based Incentive Payment System (MIPS) with more flexibility, potential for significant bonuses, lower maximum penalties</td>
</tr>
<tr>
<td>• Limited support for new payment and delivery models through Centers for Medicare and Medicaid Services Innovation</td>
<td>• Enhanced technical and financial support for small practices, transitional payments for new models, funding for quality measures, more timely physician access to performance data</td>
</tr>
</tbody>
</table>
Physicians Have Choices

**FFS**
- 0.5% July 2015 thru 2019; 0% 2020-25;
- After that: those in APM get 0.75%; others get 0.25%
- Former reporting programs consolidated into MIPS with greater flexibility
- Penalty risks reduced, potential bonuses added
- Benchmarks set prospectively, more timely feedback on performance

**APMs**
- Physicians role in creating new models specified
- 5% update bonuses for 6 years aids transition to new 2-sided risk models
- Demonstrated savings will produce higher payments
- Participants exempt from MIPS

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2019 Penalties Compared

<table>
<thead>
<tr>
<th>Prior Law</th>
<th>2019 Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS</td>
<td>-2%</td>
</tr>
<tr>
<td>MU</td>
<td>-5%</td>
</tr>
<tr>
<td>VBM</td>
<td>-4% or more*</td>
</tr>
<tr>
<td><strong>Total Penalty Risk</strong></td>
<td>-11% or more*</td>
</tr>
</tbody>
</table>

| Bonus Potential (VBM only) | Depends on the size and number of penalties |

<table>
<thead>
<tr>
<th>MIPS Factors</th>
<th>2019 Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Penalty Risk</strong></td>
<td>Capped at -4%</td>
</tr>
<tr>
<td>Bonus Potential</td>
<td>As high as 4% with the potential to earn as much as 3 times that amount, in addition to a potential 10% for exceptional performers</td>
</tr>
</tbody>
</table>

*VBM has been in effect for 3 years, and penalty risk has increased in each of these years; there are no floors on penalties. 2019 number would not have been issued until November 2018. Budget neutral funding for bonuses.
What is MIPS?

MIPS Component Weights

MIPS Component Categories (first performance year)

- Quality - 60%
- Advancing Care Information - 25%
- Resource Use - 0%
- Improvement Activities - 15%

Quality (60%) + Cost (0%) + Advancing Care Information (25%) + Improvement Activities (15%) = Final Score
Merit-Based Incentive Payment System (MIPS)

• Streamlines PQRS, VPBM and EHR Meaningful Use programs
  – Existing penalties sunset at the end of 2018
• Assesses the performance of EPs based on 4 categories:
  – Quality
  – Cost (not scored in the first year)
  – Advancing Care Information (EHR)
  – Improvement Activities

Merit-Based Incentive Payment System (MIPS)

• EPs will receive a final performance score (0-100) based on their performance in the 4 categories.
• Final score will be compared to a performance threshold.
  – Mean or median of all composite performance scores for all MIPS EPs during prior period.
Merit-Based Incentive Payment System (MIPS)

• In some cases, CMS may determine a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider’s quality performance score to make up the difference.

Merit-Based Incentive Payment System (MIPS)

• Positive, negative or neutral adjustment based on composite score.
• Negative adjustment: capped at 4% in 2019, 5% in 2020, 7% in 2021 and 9% in 2022.
  – EPs between 0 and ¼ of threshold get maximum negative penalty
  – EPs closer to threshold score get small negative payment adjustments
Merit-Based Incentive Payment System (MIPS)

• If EP’s composite score is at the threshold - will not receive a MIPS payment adjustment.
• Positive adjustment: higher performance scores receive proportionally larger incentive payments up to 3 times the annual cap for negative payment adjustments.
  – Additional incentive payment for exceptional performance (above 25th percentile).

Implementation of MACRA (Quality Payment Program)

• Final rule released on October 14
• Incorporates the majority of the flexibility and reduced reporting burdens advocated by ASCRS and the medical community in comments on the proposed rule:
  – Flexible and reduced first performance period to avoid a penalty
  – Reduced Quality reporting threshold
  – Eliminated the cross-cutting measure requirement
  – Resource Use not scored in year 1
  – Reduced number of ACI measures
• Individual or Group Reporting
• ASCRS requested delay in implementation, reduced thresholds, Resource Use scored at 0% in first year and reinstatement of measure groups.
QPP final rule included several options for the first performance period (2017) to avoid a penalty in 2019:

- **To avoid the penalty, physicians can report:**
  - One quality measure for one patient, and not have to meet the measure benchmark, or
  - One improvement activity, or
  - The required base measures for Advancing Care Information (ACI)

- **To be eligible for a small bonus and avoid a penalty, providers can choose to report for at least 90 days:**
  - Two or more quality measures on one patient, and not have to meet the measure benchmarks, or
  - More than one improvement activity, or
  - The required base measures and additional performance measures for ACI
2017 Performance Period Options (3 of 4)

• Providers who report all the required measures and meet thresholds and benchmarks in each of the categories for at least 90 days—or up to a full year—have the greatest potential for a bonus (and avoid the penalty).
  – 90-day performance period can begin anytime between January 1 and October 2, 2017.

2017 Performance Period Options (4 of 4)

• If a MIPS-eligible clinician does not report even one measure or activity in 2017, he or she will receive the full negative 4% penalty in 2019.
• MIPS-eligible clinicians who participate in Advanced APM entities that meet the required revenue or patient thresholds will receive a 5% bonus.
2017 MIPS Performance Benchmark

• To avoid a penalty for 2019 payments, a provider must score at the 2017 MIPS performance benchmark of 3 points.
• Reporting one quality measure on one patient, one improvement activity, or the base measures for ACI on one patient will achieve a MIPS score of 3 and avoid the penalty.
• Physicians can earn additional MIPS points by reporting more data for the potential to earn a bonus.
• A MIPS performance score of 70 or above qualifies as “exceptional performance” and is eligible for additional incentive payments.

Individual or Group Reporting

• MACRA statute required CMS to accept and score MIPS data either individually or as a group.
• Practices with two or more providers in the same TIN can choose to aggregate their performance data and submit as a group.
  • If reporting as a group, all providers in the TIN are included in the group.
    – Except: New Medicare provider, or Advanced APM participants.
    – Low Volume Threshold providers will be included in group performance and score.
• Providers who bill under multiple TINs would have to satisfy the MIPS requirements for each TIN.
  – For example: a provider splitting time 50/50 between two practices. If one practice reports the part-time physician’s performance as part of a group, the services performed for that practice are included in the group score. However, he or she must still report on performance under the other TIN.
Program Modifications and Weights for Each of the Four Categories

• Quality (60% of total score in year 1)
  ➢ Report a minimum of six measures, with at least one outcome measure, if available. Otherwise, provider would report one additional “high priority” measure.
  ➢ Report on 50% of all patients via registry and EHR (IRIS reports as EHR if using EHR integration) or 50% of Medicare Part B patients via claims.
  ➢ Eliminates Measures Groups option- Cataract and Diabetic Retinopathy.

Available Ophthalmology MIPS Quality Measures- 1 of 2 (* high priority measure)

<table>
<thead>
<tr>
<th>NQF/FQMS Number</th>
<th>Submission Mechanism</th>
<th>Measure Type</th>
<th>Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>0086/012</td>
<td>Claims, Registry, EHR</td>
<td>Process</td>
<td>Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation</td>
</tr>
<tr>
<td>063/014</td>
<td>Claims, Registry</td>
<td>Process</td>
<td>Age-Related Macular Degeneration (AMD): Dilated Macular Examination</td>
</tr>
<tr>
<td>0088/018</td>
<td>EHR</td>
<td>Process</td>
<td>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</td>
</tr>
<tr>
<td>0089/019</td>
<td>Claims, Registry, EHR</td>
<td>Process</td>
<td>Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care*</td>
</tr>
<tr>
<td>0326/047</td>
<td>Claims, Registry</td>
<td>Process</td>
<td>Comprehensive Medication Plan*</td>
</tr>
<tr>
<td>0566/140</td>
<td>Claims, Registry</td>
<td>Process</td>
<td>Documentation of Current Medications in the Medical Record*</td>
</tr>
<tr>
<td>0567/141</td>
<td>Claims, Registry</td>
<td>Process</td>
<td>Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplementation</td>
</tr>
<tr>
<td>0568/142</td>
<td>Claims, Registry</td>
<td>Outcome</td>
<td>Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% or Documented Plan of Care*</td>
</tr>
<tr>
<td>0569/150</td>
<td>Registry, EHR</td>
<td>Outcome</td>
<td>Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery*</td>
</tr>
</tbody>
</table>
Available Ophthalmology MIPS Quality Measures -2 of 2 (* high priority measure)

<table>
<thead>
<tr>
<th>NQF/PQRS Number</th>
<th>Submission Mechanism</th>
<th>Measure Type</th>
<th>Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>0564/192</td>
<td>Registry, EHR</td>
<td>Outcome</td>
<td>Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures *</td>
</tr>
<tr>
<td>0028/226</td>
<td>Claims, Registry, EHR, Web Interface</td>
<td>Process</td>
<td>Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
</tr>
<tr>
<td>1536/303</td>
<td>Registry (not available in IRIS for 2017)</td>
<td>Outcome</td>
<td>Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery*</td>
</tr>
<tr>
<td>N/A/317</td>
<td>Claims, Registry, EHR</td>
<td>Process</td>
<td>Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
</tr>
<tr>
<td>N/A/374</td>
<td>EHR</td>
<td>Process</td>
<td>Closing the Referral Loop: Receipt of Specialist Report*</td>
</tr>
<tr>
<td>N/A/384</td>
<td>Registry</td>
<td>Outcome</td>
<td>Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room within 90 Days of Surgery*</td>
</tr>
<tr>
<td>N/A/385</td>
<td>Registry</td>
<td>Outcome</td>
<td>Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement within 90 Days of Surgery*</td>
</tr>
<tr>
<td>N/A/388</td>
<td>Registry</td>
<td>Outcome</td>
<td>Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy)*</td>
</tr>
<tr>
<td>N/A/389</td>
<td>Registry</td>
<td>Outcome</td>
<td>Cataract Surgery: Difference Between Planned and Final Refraction*</td>
</tr>
<tr>
<td>N/A/402</td>
<td>Registry</td>
<td>Process</td>
<td>Tobacco Use and Help with Quitting Among Adolescents</td>
</tr>
</tbody>
</table>

Quality Category Score

- Unlike under PQRS, where providers simply had to report on certain measures to achieve an incentive or avoid a penalty, providers under the MIPS program must now demonstrate improved quality above a baseline level.

- For full credit in the Quality Category, physicians must achieve a total of 60 or 70 possible points.
  - Practices of 15 or fewer must report on 6 measures, each with a total 10 possible points
  - Practices of 16 or more must report on 6 measures, and will have the hospital-readmission measure calculated by CMS if 200 patients are attributed, each with a total 10 possible points (70 points)
  - Practices of 16 or more that do not have 200 patients attributed for the hospital re-admission measure will be scored out of 60 possible points.

- CMS set the 2017 performance period baseline based on 2015 PQRS performance.
Quality Category Score

• Each measure reported will receive a score between 3 and 10, based on how well the provider achieved on the measure relative to the preset benchmark.
• Each measure has a benchmark for each type of submission mechanism.
• Each benchmark is presented in terms of deciles (ten point scales).
  – Each measure has different levels of performance assigned to each decile.
  – Each decile is a range of performance levels for each measure that correspond to points earned for the measure.
  – For example, if you submit data showing 83% performance on the measure, and the 5th decile begins at 72% performance and the 6th decile begins at 85% performance, then you will receive between 5 and 5.9 points because 83% is in the 5th decile.
• Visit ascrs.org/macracenter to download the benchmarks.

Quality Category Score

• For the first performance year (2017) CMS is setting a measure “floor” of 3 points.
  – No measure will be scored less than 3 points, even if the provider did not meet the benchmark, the data submission threshold, or the 20 case minimum.
  – 3-point “floor” corresponds to the overall MIPS score of 3 for the first performance period to avoid a penalty.
• The Quality performance category score will be the sum of the points assigned based on his or her quality reporting divided by the total available points, depending on practice size.
• The Quality category score will then be weighted to count for 60% of the total MIPS score.
Quality Category Score – Bonus Points

- **Possible bonus points**: incentive to report on additional “high priority” measures:
  - Two bonus points for each additional outcome measure reported beyond the required one, OR
  - One bonus point for each other additional “high priority” measure.

- Bonus points for reporting high priority measures – including outcome measures - are capped at 10% of the total available category points. (6 points)

- Each quality measure reported through electronic submissions, such as EHR or qualified data registry, will earn an additional bonus point, up to 10% of available points—in addition to the bonus points for reporting high priority and outcome measures. (6 points)

Advancing Care Information Category

- 25% of total score in year 1
  - Comprised of a score for participation and reporting 5 objectives and their measures (base score – 50 points) and a score for reporting at various levels above the base score (performance score)
  - Performance score – potential to earn up to 90 points in the objectives and measures for patient electronic access, coordination of care through patient engagement, and health information exchange.
  - Earn up to 15 bonus points for use of public health and clinical data registries, and completing improvement activities with EHR.
  - Physicians who score 100 points will earn full credit for the category; however there are 155 available points in the category.
  - Modified requirements for practices with 2014 technology
Advancing Care Information (ACI)
Category Score Calculation

**BASE SCORE**
- Makes up to 50 Points of the total ACI performance category score

**PERFORMANCE SCORE**
- Makes up to 90 Points of the total ACI Performance Category Score

**BONUS POINTS**
- Up to 15 Points of the total ACI Performance Category Score

**COMPOSITE SCORE**
- Earn 100 or more points and receive Full 25 Points in the ACI Category of MIPS Composite Score

Earn > 100 Points, overall MIPS Score declines proportionally

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**Advancing Care Information Base Score Objectives**

- **Protect Health Information** (yes required)
- **Electronic Prescribing** (numerator/denominator)
- **Patient Electronic Access** (numerator/denominator)
- **Health Information Exchange** (numerator/denominator)
### ACI Base Score Objectives & Measures
(2015 Certified Technology)

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measure</th>
<th>Base Measure Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
<td>Yes/No, must answer Yes</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>ePrescribing</td>
<td>Numerator/denominator, must have 1 in the numerator</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Patient Access*</td>
<td>Numerator/denominator, must have 1 in the numerator</td>
</tr>
<tr>
<td>Health Information Exchange*</td>
<td>Send a Summary of Care*</td>
<td>Numerator/denominator, must have 1 in the numerator</td>
</tr>
<tr>
<td></td>
<td>Request/Accept Patient Care Record Measure *</td>
<td>Numerator/denominator, must have 1 in the numerator</td>
</tr>
</tbody>
</table>

*these measures may be selected for the performance score

### Advancing Care Information Performance Score – 90 Points

- Patient Electronic Access
- Coordination of Care Through Patient Engagement
- Health Information Exchange
- Public Health and Clinical Data Registry Reporting
ACI Performance Score Measure Calculation

• Each measure reported will be calculated individually by dividing the numerator by the denominator.
  – A performance rate of 1% to 10% will be scored 1 point, a performance rate of 11% to 20% will earn 2 points, and so on.
  – Example: If a provider reports that 85 out of 100 possible patients were included in the Patient-Specific Education Measure, then the performance rate would be 85% and earn the provider 9 points toward the performance score.

### ACI Performance Score Objectives and Measures
(2015 CEHRT)

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measure</th>
<th>Performance Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Electronic Access</td>
<td>Patient Access</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td></td>
<td>Patient-Specific Education</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td>Care Coordination Through Patient Engagement</td>
<td>View, Download, Transmit</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td></td>
<td>Secure Messaging</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td></td>
<td>Patient-Generated Data</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td>Health Information Exchange*</td>
<td>Send a Summary of Care</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td></td>
<td>Request/Accept Patient Care Record Measure</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td></td>
<td>Clinical Information Reconciliation</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Immunization Registry Reporting</td>
<td>0 or 10 points</td>
</tr>
<tr>
<td></td>
<td>Syndromic Surveillance Reporting</td>
<td>Bonus (5 points)</td>
</tr>
<tr>
<td></td>
<td>Electronic Case Reporting</td>
<td>Bonus (5 points)</td>
</tr>
<tr>
<td></td>
<td>Public Health Registry Reporting</td>
<td>Bonus (5 points)</td>
</tr>
<tr>
<td></td>
<td>Clinical Data Registry Reporting</td>
<td>Bonus (5 points)</td>
</tr>
</tbody>
</table>
### 2017 Advancing Care Information Transition Objectives and Measures
(for participants with 2014 CEHRT)

<table>
<thead>
<tr>
<th>2017 ACI Transition Objectives</th>
<th>2017 Transition ACI Measures</th>
<th>Required/Not Required for the Base Score</th>
<th>Performance Score</th>
<th>Reporting Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
<td>Required</td>
<td>0</td>
<td>Yes/no statement</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>E-Prescribing</td>
<td>Required</td>
<td>0</td>
<td>Numerator/denominator</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access</td>
<td>Required</td>
<td>Up to 20 points</td>
<td>Numerator/denominator</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>View, Download, or Transmit</td>
<td>Not required</td>
<td>Up to 10 points</td>
<td>Numerator/denominator</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td>Patient-Specific Education</td>
<td>Not required</td>
<td>Up to 10 points</td>
<td>Numerator/denominator</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Secure Messaging</td>
<td>Not required</td>
<td>Up to 10 points</td>
<td>Numerator/denominator</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Health Information Exchange</td>
<td>Required</td>
<td>Up to 20 points</td>
<td>Numerator/denominator</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Medication Reconciliation</td>
<td>Not required</td>
<td>Up to 10 points</td>
<td>Numerator/denominator</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>Immunization Registry Reporting</td>
<td>Not required</td>
<td>0 or 10 points</td>
<td>Yes/no statement</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>Syndromic Surveillance Reporting</td>
<td>Not required</td>
<td>Bonus</td>
<td>Yes/no statement</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>Specialized Registry Reporting</td>
<td>Not required</td>
<td>Bonus</td>
<td>Yes/no statement</td>
</tr>
</tbody>
</table>

**Bonus up to 15%**

- Report to one or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure
  - 5 point Bonus
  - Yes/no statement
- Report improvement activities using CEHRT
  - 1 point Bonus
  - Yes/no statement

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### Improvement Activities Category

- **15% of total score in year 1**
  - Work toward a total of 40 points by selecting IAs.
  - Select activities from a list of more than 90 options, such as care coordination, beneficiary engagement, and patient safety.
  - Medium level activities worth 10 points; high level activities worth 20 points.
  - Eased requirements for small practices (15 or fewer Medicare providers)- one high weighted, or two medium-weighted activities.
  - Report activities through attestation: registry, EHR, or CMS will provide an attestation site.
Selected Improvement Activities

The final rule includes a list of 94 individual activities. The activities are grouped in eight subcategories corresponding to CMS’ stated goals. Providers may choose any combination of activities, regardless of category. **High-weighted activities in red.**

<table>
<thead>
<tr>
<th>Expanded Practice Hours</th>
<th>Population Management</th>
<th>Data Coordination</th>
<th>Beneficiary Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Expanded practice hours, Telehealth services, and Participation in models designed to improve access to services</td>
<td>- Participation in chronic care management programs, Participation in rural and Indian Health Services programs, Participation in community programs with other stakeholders to address population health, and Use of a Qualified Clinical Data Registry (QCDR) to track population outcomes</td>
<td>- Use of a QCDR to share information, timely communication and follow-up, Participation in various CMS models designed to improve care coordination, i.e. CMS Transforming Clinical Practice Initiative, Implementation of care coordination training, implementation of plans to handle transitions of care, and Active referral management</td>
<td>- Use of EHR to document patient-reported outcomes, Providing enhanced patient portals, Participation in a QCDR that promotes the use of patient engagement tools, and Use of QCDR patient experience data to inform efforts to improve beneficiary engagement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Safety and Practice Assessment</th>
<th>Achieving Health Equity</th>
<th>Emergency Response and Preparedness</th>
<th>Integrated Behavioral and Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Use of QCDR data for ongoing practice assessments and patient safety improvements, and Use of tools such as the Surgical Risk Calculator Participation in a prescription drug-monitoring program</td>
<td>- Seeing new and follow-up Medicaid patients in a timely manner, and Use of QCDR for demonstrating performance of processes for screening for social determinants</td>
<td>- Participation in disaster medical teams or participation in domestic or international humanitarian volunteer work</td>
<td>- Tobacco intervention and smoking cessation efforts, and Integration with mental health services</td>
</tr>
</tbody>
</table>

### Improvement Activities Documentation

- CMS released suggested documentation for each of the 94 improvement activities.
- High-weighted activities frequently chosen by ophthalmic practices documentation examples:
  - **Extended practice hours:** claims/medical records indicating service was performed outside of business hours.
  - **Use of a Qualified Clinical Data Registry (QCDR), such as IRIS:** retain copies of registry feedback reports.
Resource Use or Cost Category

0% of total score in year 1
- Includes two of the cost measures previously used in VBPM program: total per capita costs for all attributed beneficiaries and Medicare spending per beneficiary.
- Attribution method unchanged – two step process
- Episode-based measures will be used to evaluate resource use, as applicable.
- Episode measure for cataract surgery included
- No reporting necessary

APMs – Advanced Alternative Payment Models

- Encouraging Advanced Alternative Payment Model (APM) participation
  - Physicians who participate in APMs that collectively meet thresholds for a percentage of revenues or eligible patients (25% in 2019, 2020) through an APM that involves:
    - Risk of financial loss;
    - A quality measure component; and
    - Requirement that a majority of participating clinicians are using certified EHR technology
  - Will receive 5% bonus each year from 2019-2024.
- Excluded from MIPS and most EHR Meaningful Use requirements
- Two types of Advanced APMs – Advanced APMs and Other Payer Advanced APMs
- Participants in entities who do not meet required thresholds and participants in models not considered Advanced APMs can earn credit for MIPS
APMs – Advanced Alternative Payment Models

• **Advanced APMs** include ACOs (2-sided risk), medical homes, and episode payment models

• **Other Payer APMs** include payment arrangements under any payer other than traditional Medicare - including Medicare Advantage and other Medicare-funded private plans.

➢ Medicare Advantage counts toward APM thresholds, but not towards the payment calculation in the Alternative Payment Model Incentive Payments program.

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APM’s – Advanced Alternative Payment Models

• For year 1 –
  - Physicians must participate in APM entities that collectively derive at least 25% of Medicare payment amounts or include 20% of eligible Medicare patients from the APM to receive bonus payment for qualified participation (QP). (increases in following years)

<table>
<thead>
<tr>
<th>Requirements for Incentive Payments for Significant Participation in Advanced APMs (APM Entities must collectively meet payment or patient requirements)</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024 or later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Payments through an Advanced APM</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Percentage of Patients through an Advanced APM</td>
<td>20%</td>
<td>20%</td>
<td>35%</td>
<td>35%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
MIPS APMs

- Physicians participating in certain APMs may earn MIPS credit through their participation in selected models.
- Physicians who do not meet thresholds for full participation in Advanced APMs or participate in models that do not qualify as “advanced” are eligible to earn MIPS credit under the MIPS APM scoring standard.
- All Advanced APMs are MIPS APMs, as well as other approved models—such as Medicare Shared Savings Program Track 1 ACOs—which do not incorporate two-sided risk.
- All participants in the MIPS APM earn the same score and payment adjustment.
- Track 1 ACO participants:
  - Report Quality measures through the ACO
  - Report ACI category individually, but all participants’ scores are averaged
  - Earn full credit in Improvement Activities category.
  - MIPS Categories re-weighted to: Quality 50%, Cost 0%, Improvement Activities 20%, ACI 30%

Data Validation and Auditing

- CMS has released data validation criteria to evaluate data submitted in the 2017 performance year.
  - Quality: will focus on determining whether physicians submit all applicable measures if submitting less than six, or not submitting outcome or high priority measure.
  - Improvement Activities: CMS released a list of suggested documentation for each of the 94 improvement activities.
  - Advancing Care Information: practices should retain documentation related to the category.
- Audits on 2017 will only cover Quality category.
  - All payer data submissions will not be the sole factor in audits to determine whether a physician passes or not.
  - Practices have 10 days to respond to audit requests.
Additional Provisions of MACRA

- MACRA required CMS to develop:
  - Episode groups
  - Patient relationship codes
  - Patient condition codes

- These efforts are intended to better attribute costs of care for resource use measurement and develop episode-based payment models, which could qualify as Advanced APMs.

- CMS has asked for feedback on episode measures on several occasions. ASCRS provided comments and is working on a response to a new proposal.

- ASCRS has provided comments on two patient relationship category and codes requests for information.

- Physicians will be required to report patient relationship codes (in the form of modifiers) beginning in January, 2018.

ASCRS Key Recommendations for 2018 and Beyond

- Retain performance period flexibility for 2018 and beyond (3 more years).
- Simplify and streamline the MIPS program and scoring
- Reinstate Quality Measures Groups.
- Keep the Resource Use category at 0% for 2018 and beyond (3 more years).
- Resolve the attribution, risk adjustment, and cost methodology issues in the Resource Use Category.
- Eliminate the one-size-fits-all mentality.
- Topped-out measures.
- Transparency and accountability with CMS and the contractors – development of episode groupers
- Remove ACI measures out of the control of the physician-patient engagement, health information exchange.
- CMMI needs more transparency and accountability – alternative payment models.
ASCRS•ASOA MACRA Resources

- MACRA Center – ascrs.org/macracenter
  - Guides
  - FAQs
  - Top Tips
- MACRA Hotline – 703-383-5724
- Digital Download of Diving into the Details of MACRA
Thank you!

Questions?
nmccann@ascrs.org