Putting the Pieces Together
Practical Solutions for the GI Practice

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)
ADVANCING CARE INFORMATION CATEGORY

QUALITY PAYMENT PROGRAM FINAL RULE SUMMARY

Synopsis —

The Medicare Reauthorization and CHIP Act of 2015 (MACRA) sunsets the Electronic Health Record (EHR) Incentive Program as established under the HITECH Act. EHR meaningful use, however, is included as a performance category under the Merit-Based Incentive Payment System (MIPS), which is newly referred to as the "Advancing Care Information" (ACI) performance category. Under MACRA, CMS maintains the definition of certified EHR technology (CEHRT) and uses the Stage 3 EHR meaningful use objectives and measures as the basis for the new ACI category. Most notably, CMS moves away from the widely criticized "all-or-nothing" performance approach under the Meaningful Use program. Instead, under MIPS, CMS incentivizes, through a flexible scoring methodology, continuous improvement and recognizes on-boarding efforts among late adopters and those clinicians without prior experience with certified EHR technology or the Meaningful Use Program, as well as among MIPS eligible clinicians who have struggled to implement certified EHR technology in their practices and/or fulfill the meaningful use requirements.

The scoring methodology used for the ACI category includes both base and performance scores, as well as bonus points, that can be combined for a total score of 155. This flexible methodology encourages more robust use of EHR technology, without penalizing early adopters. Certain measures, like health information security, remain a priority for CMS which is demonstrated in the scoring methodology. In 2017, there are two measure set options for reporting. Which option an eligible clinician chooses will be based on their electronic health record edition.

For the purpose of MIPS, Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists are eligible clinicians. However, these clinicians can choose whether to report ACI measures for the 2017 performance period.

Provisions for the ACI category start on page 695 of the final rule.

In Brief: What Do You Need to Do?

1. Fulfill the required measures for a minimum of 90 days:

    - Security Risk Analysis
    - e-Prescribing
    - Provide Patient Access
    - Send Summary of Care
    - Request/Accept Summary of Care

2. Choose to submit up to 9 measures for a minimum of 90 days for additional credit OR

3. You may not need to submit Advancing Care Information if these measures do not apply to you.

PROPOSED RULE	FINAL RULE
CLINICAL QUALITY MEASUREMENT USING CEHRT	
CMS did not propose separate requirements for clinical quality reporting under the ACI category. Instead, quality data would be submitted through the Quality performance category, in which CMS encourages the reporting of quality data using EHR technology.	CMS has not included separate requirements for clinical quality measurement in the ACI category. CMS will require submission of quality data for measures specified for the quality performance category, in which it will encourage reporting of CQMs with data captured in CEHRT.
PERFORMANCE PERIOD	
CMS proposed to align the performance period for the ACI category with the proposed MIPS performance period — one full calendar year. CMS proposed to eliminate the 90-day reporting period.	CMS is finalizing its proposal to align the performance period for the ACI category with the MIPS performance period of one full calendar year. For the first performance period of CY 2017, CMS will accept a minimum of 90 days of data within CY 2017. In recognition of the switch from CEHRT certified to the 2014 Edition to CEHRT certified to the 2015 Edition, for the 2018 performance period CMS will accept a minimum of 90 days of data within CY 2018. CMS encourages MIPS eligible clinicians to submit data for the full year performance period.

DATA SUBMISSION AND COLLECTION

For 2017, CMS proposed to allow MIPS eligible clinicians to use EHR technology certified to the 2014 or 2015 edition.

— Technology certified to the 2015 Edition. Choose to report: (1) on the objectives and measures specified for the advancing care information performance category which correlate to Stage 3 requirements; or (2) on the alternate objectives and measures which correlate to modified Stage 2 requirements.

— Technology certified to a combination of 2015 Edition and 2014 Edition. Choose to report: (1) on the objectives and measures specified for the advancing care information performance category which correlate to Stage 3; or (2) on the alternate objectives and measures which correlate to modified Stage 2, if they have the appropriate mix of technologies to support each measure selected.

— Technology certified to the 2014 Edition. Cannot report on any of the measures specified for the advancing care information performance category that correlate to a Stage 3 measure that requires the support of technology certified to the 2015 Edition. These MIPS eligible clinicians would be required to report on the alternate objectives and measures which correlate to modified Stage 2 objectives and measures.

Beginning in 2018, MIPS eligible clinicians must only use technology certified to the 2015 edition.

CMS is finalizing its proposal without modification.

In 2017, MIPS eligible clinicians may use EHR technology certified to the 2014 Edition or the 2015 Edition or a combination of the two.

A MIPS eligible clinician who only has technology certified to the 2014 Edition would not be able to report certain measures specified for the advancing care information performance category that correlate to a Stage 3 measure for which there was no Stage 2 equivalent. These MIPS eligible clinicians may instead report the objectives and measures specified for the advancing care information performance category which correlate to Modified Stage 2 objectives and measures.

In 2018, MIPS eligible clinicians must use EHR technology certified to the 2015 Edition. CMS encourages MIPS eligible clinicians to work with their EHR vendors in the coming months to prepare for the transition to 2015 Edition in for the performance period in CY 2018.

CMS clarifies that removing a measure from the reporting requirements does not remove the functions supporting that measure from the definition of CEHRT unless corresponding changes to that definition are made.

METHOD OF DATA SUBMISSION	
In 2017, CMS proposed that EHRs (through the QRDA submission method), Qualified Clinical Data Registries (QCDRs) and qualified registries could submit ACI objectives and measures to CMS. Data could also be submitted through the CMS Web Interface.	CMS recognizes that some Health IT vendors, QCDRs and qualified registries may not be able to conduct this type of data submission for the 2017 performance period. However, CMS is including these data submission mechanisms in 2017 to support early adopters and to signal a longer-term commitment to working with organizations to create less burdensome data submission mechanisms. CMS offers the option of attestation for those MIPS eligible clinicians who's CEHRT, QCDR or registry are not prepared to support ACI data submission in 2017.
SCORING METHODOLOGY	
CMS proposed the ACI category would comprise 25 percent of a MIPS eligible clinician's composite performance score for payment year 2019 and each year thereafter. The score would be comprised of a base score (score for participation and reporting) and a score for performance.	The total possible score for the ACI category is increased to 155 percent (Base Score = 50 points; Performance Score = 90 points; Bonus Score = 15 points) which would be capped at 100 percent when applied to the 25 possible points for the ACI category in the MIPS final score.

Putting the Pieces Together
Practical Solutions for the GI Practice

BASE SCORE

To earn points toward the base score, a MIPS eligible clinician must report the numerator and denominator of certain measures to earn 50 percent (out of a total 100 percent). For any measure requiring a yes/no statement, only a yes statement would qualify for credit under the base score.

CMS proposed a primary and an alternate proposal for base scoring . Both proposals would require the MIPS eligible clinician to meet the requirement to protect patient health information created or maintained by certified EHR technology to earn any score within the advancing care information performance category; failure to do so would result in a base score of zero, a performance score of zero, and an advancing care information performance category score of zero.

The Base score is worth 50 points of the total ACI score.

CMS reduced the total number of required measures from 11 in the base score as proposed to only 5 in the final policy.

For required measures in the base score, CMS would still require a one in the numerator or a "yes" response to yes/no measures.

For any measure requiring a yes/no statement, only a yes statement would qualify for credit under the base score.

Required base score measures include: 1) e-Prescribing; 2) Send a Summary of Care (formerly Patient Care Record Exchange); 3) Request/Accept Summary of Care (formerly Patient Care Record); 4) Security Risk Analysis; and 5) Provide Patient Access (formerly Patient Access).

The base score accounts for 50 percent (out of a total 100 percent) of the ACI score.

Important Note: Eligible clinicians who use 2014 edition CEHRT and choose to report 2017 Advancing Care Information Transition Objectives and Measures (see below) will report on 4 required measures to earn a base score of 50 percent. These measures include: 1) Security Risk Analysis; 2) E-Prescribing; 3) Provide Patient Access; and 4) Health Information Exchange.

Putting the Pieces Together
Practical Solutions for the GI Practice

BASE SCORE PRIMARY PROPOSAL	
Requires a MIPS eligible clinician to report the numerator (of at least one) and denominator or yes/no statement (only a yes statement would qualify for credit under the base score) for a subset of measures. Two objectives (Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE)) and their associated measures would not be required under the Primary Proposal. However, these measures would still be required as part of ONC's functionality standards for certified EHR technology.	CMS did not finalize a primary and alternative proposal. Instead, MIPS eligible clinicians are required to report on of the required measures for the base score to earn any points in the ACI category. A MIPS eligible clinician must report either a one in the numerator for numerator/denominator measures, or a "yes" response for yes/no measures in order to earn points in the base score, and a MIPS eligible clinician must report <u>all required measures</u> in the base score in order to earn a score in the ACI category. The remainder of a MIPS eligible clinician's score will be based on performance and/or meeting the requirements to earn a bonus score for Public Health and Clinical Data Registry Reporting or Improvement Activities.
Base Score Alternate Proposal	
Requires a MIPS eligible clinician to report the numerator (of at least one) and denominator or yes/no statement (only a yes statement would qualify for credit under the base score) for all objectives and measures. The Alternate Proposal would require reporting a yes/no statement for CDS and a numerator and denominator for CPOE objectives.	See final policy under "Base Score Primary Proposal." The base score will not include the reporting of the objectives and measures for CDS and CPOE.

PROTECTING PATIENT INFORMATION	
CMS proposed the Patient Health Information objective and measure would be an overarching requirement for the base score under both the primary proposal and alternate proposal. CMS proposed that a MIPS eligible clinician must meet this objective and measure in order to earn any score within the ACI category	CMS is finalizing the requirement that a MIPS eligible clinician must meet the Protect Patient Health Information objective and measure in order to earn any score within the ACI category. CMS noted the HIPAA Privacy and Security Rules, which are more comprehensive than the ACI measure and with which certain entities must also comply, have been effective for over 10 years. CMS further noted that HHS as produced a security risk assessment tool designed for use by small and medium sized providers and clinicians.
BONUS POINTS	
CMS proposed that MIPS eligible clinicians could earn up to 1 bonus point under by reporting to additional registries under the Public Health and Clinical Data Registry Reporting measure.	CMS is increasing the bonus score to 5 percent in the ACI category score for reporting to one or more public health or clinical data registries beyond the Immunization Registry Reporting measure. The bonus is only available to MIPS eligible clinicians who earn a base score. MIPS eligible clinicians are not required to report the Immunization Registry Reporting measure to earn the bonus 5 percent for reporting to one or more additional registries. CMS has identified a set of activities from the Clinical Practice Improvement Activities category that can be tied to the objectives, measures, and CEHRT functions of the ACI category and would thus qualify for the bonus in the ACI category. (See Table 8, pgs. 707-713) CMS will award a 10 percent bonus in the ACI category if a MIPS eligible clinician attests to completing at least one of the improvement activities specified in Table 8 using CEHRT. 10 percent is the maximum bonus a MIPS eligible clinician will receive whether they attest to using CEHRT for one or more of the activities listed in Table 8. The weight of the improvement activity has no bearing on the bonus awarded in the ACI category.

Modified Stage 2 for 2017	
For those MIPS eligible clinicians utilizing EHR technology certified to the 2014 Edition, CMS proposed modified primary and alternate proposals for the base score. Scoring and data submission would be the same as the primary and alternate proposals, but the measures would vary under the Coordination of Care Through Patient Engagement and Health Information Exchange objectives.	In the final rule, CMS replaces the term "Modified Stage 2" with **"**2017 Advancing Care Information Transition Objectives and Measures**"** MIPS eligible clinicians have the option to report for the 2017 performance period using EHR technology certified to the 2014 Edition or a combination of both 2014 and 2015 Editions. In 2017, a MIPS eligible clinician who has technology certified to a combination of 2015 Edition and 2014 Edition may choose to report on either the ACI objectives and measures specified for the ACI category or the 2017 Advancing Care Information Transition Objectives and Measures if they have the appropriate mix of technologies to support each measure selected. If a MIPS eligible clinician switches from 2014 Edition to 2015 Edition CEHRT during the performance period, the data collected for the base and performance score measures should be combined from both the 2014 and 2015 Edition of CEHRT.
PERFORMANCE SCORE	
CMS proposed a MIPS eligible clinician would earn additional points above the base score for performance in the objectives and measures for Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange. Eight associated measures under these three objectives would each be assigned 10 possible points for a total of 80 possible points.	A MIPS eligible clinician would earn additional points above the base score for performance in the objectives and measures for Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange. CMS has finalized nine measures for the performance score. A MIPS eligible clinician has the ability to earn up to 90 percentage points if they report all measures in the performance score. A performance rate of 1-10 percent would earn 1 percentage point, a performance rate of 11-20 percent would earn 2 percentage points and so on. For example, if the clinician reports a numerator/denominator of 85/100 for the Patient-Specific Education measure, their performance rate would be 85 percent and they would earn 9 percentage points toward their performance score.

OVERALL ACI PERFORMANCE SCORE

To determine the MIPS eligible clinician's overall ACI score, CMS proposed to use the sum of the base score (max 50), performance score (max 80), and the potential Public Health and Clinical Data Registry Reporting bonus point (max 1).

The total percentage score (out of 100) for the ACI category would be multiplied by the weight (25 percent) of the ACI category and incorporated into the MIPS final score.

Under the final policy, a MIPS eligible clinician must report all required measures of the base score to earn any base score, and thus to earn any score in the ACI category.

In 2017, there are two measure set options for reporting. The option is based on the electronic health record edition.

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

See Table 9 (page 768) for Advancing Care Information Performance Category Scoring Methodology Advancing Care Information Objectives and Measures

EHR technology certified to the 2014 Edition allows reporting on 2017 Advancing Care Information Transition Objectives and Measures only. See Table 10 (page 770)

https://qpp.cms.gov/measures/aci

The measures under the Public Health and Clinical Data Registry Reporting objective are yes/no measures and do not have a numerator/denominator to calculate the performance rate. For the Immunization Registry Reporting measure, CMS will award 0 or 10 percentage points for the performance score (0 percent for a "no" response, 10 percent for a "yes" response). Active engagement with a public health or clinical data registry to meet any other measure associated with the Public Health and Clinical Data Registry Reporting objective will earn the MIPS eligible clinician a bonus of 5 percentage points (see above).

Two of the measures in the base score are not included in the performance score: Security Risk Analysis and e-Prescribing.

Putting the Pieces Together
Practical Solutions for the GI Practice

Scoring Considerations	
The law gives CMS the authority to reduce the percentage weight of the ACI category (but not below 15 percent) in any year in which the Secretary estimates that the proportion of eligible professionals who are meaningful EHR users is 75 percent or greater. Any decrease in the weight of the ACI category would be offset by increasing the weight of other performance categories. CMS proposed to estimate the proportion of physicians who are meaningful EHR users as those physician MIPS eligible clinicians who earn an ACI score of at least 75 percent. CMS alternatively proposed a threshold of 50 percent (which would only require the MIPS eligible clinician to earn the ACI base score).	CMS has finalized a policy of determining a meaningful EHR user as those physician MIPS eligible clinicians who earn an ACI performance category score of at least 75 percent for a performance period.
Exclusions	
By excluding from MIPS those clinicians who do not exceed the low-volume threshold, CMS proposed that exclusions for most of the individual ACI measures are no longer necessary. For the purposes of the base score, CMS is proposed that those MIPS eligible clinicians who write fewer than 100 permissible prescriptions in a performance period may elect to report their numerator and denominator (if they have at least one permissible prescription for the numerator), or they may report a null value. CMS also proposed to maintain the previously established exclusions for the Immunization Registry Reporting measure.	As there are now fewer required measures, CMS does not believe it is necessary to create additional exclusions for measures which are now optional for reporting. CMS is finalizing that MIPS eligible clinicians who write fewer than 100 permissible prescriptions in a performance period may elect to report their numerator and denominator (if they have at least one permissible prescription for the numerator), or they may report a null value. Since CMS has moved the Immunization Registry Reporting measure from “required” in the base score to “not required” in the base score, it is not finalizing the proposal to provide an exclusion for those MIPS eligible clinicians who do not administer immunizations during the performance period.

REWEIGHTING OF THE ACI CATEGORY FOR MIPS ELIGIBLE CLINICIANS WITHOUT SUFFICIENT MEASURES APPLICABLE AND AVAILABLE— HOSPITAL-BASED MIPS ELIGIBLE CLINICIANS

CMS proposed to assign a weight of zero to the ACI category for hospital-based MIPS eligible clinicians. A "hospital-based MIPS eligible clinician" is a MIPS eligible clinician who furnishes 90 percent or more of his or her covered professional services in an inpatient hospital or emergency room setting in the year three years preceding the MIPS payment year. CMS is considering, however, whether a lower threshold would be more appropriate.	CMS has finalized a policy that MIPS eligible clinicians who are determined hospital-based do not have sufficient ACI measures applicable to them, and thus CMS will reweight the ACI category to zero percent of the MIPS final score for the MIPS payment year. A hospital-based MIPS eligible clinician is defined as one who furnishes 75 percent or more of his/her covered professional services in sites of service identified by Place of Service (POS) codes: in-patient hospital (POS 21); on campus outpatient hospital (POS 22), or emergency room (POS 23) setting, based on claims for a period prior to the performance period. CMS intends to use claims with dates of service between September 1 of the calendar year 2 years preceding the performance period through August 31 of the calendar year preceding the performance period.

REWEIGHTING OF THE ACI CATEGORY FOR MIPS ELIGIBLE CLINICIANS WITHOUT SUFFICIENT MEASURES APPLICABLE AND AVAILABLE—OTHER HARDSHIP EXEMPTIONS	
CMS proposed to continue to grant hardship exceptions for the ACI category for the following conditions: — Insufficient Internet Connectivity — MIPS eligible clinicians who demonstrate insufficient internet access through an application process. — Extreme and Uncontrollable Circumstances — Lack of Control over the Availability of certified EHR technology — Lack of Face-to-Face Patient Interaction CMS does not believe there would be sufficient ACI measures applicable to non-patient-facing MIPS eligible clinicians. Therefore, the ACI category would be reweighted to zero.	CMS is finalizing its policy to re-weight the ACI category to zero percent of the MIPS final score for MIPS eligible clinicians facing significant hardships as proposed. With regard to the exception for lack of control over the availability of certified EHR technology, CMS clarified the "lack of control over the availability of CEHRT" is not limited to MIPS eligible clinicians who practice at multiple locations. Instead, it is available to any MIPS eligible clinicians who may not have the ability to impact their practices' health IT decisions. CMS noted that in such cases, the MIPS eligible clinician must have no control over the availability of CEHRT. CMS further specifies that a majority (50 percent or more) of their outpatient encounters must occur in locations where they have no control over the health IT decisions of the facility. Control does not imply final decision-making authority.
NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, CLINICAL NURSE SPECIALISTS, AND CERTIFIED REGISTERED NURSE ANESTHETISTS	
CMS proposed to assign a weight of zero to the ACI category if there are not sufficient measures applicable and available to NPs, PAs, CRNAs, and CNSs. A weight of zero would be assigned only in the event that an NP, PA, CRNA, or CNS does not submit any data for any of the measures specified.	CMS is finalizing policy for NPs, PAs, CRNAs, and CNSs as proposed. These MIPS eligible clinicians may choose to submit ACI measures should they determine that these measures are applicable and available to them. However, if they choose to report, they will be scored on the ACI performance category like all other MIPS eligible clinicians and the performance category will be given the weighted at 25% regardless of their ACI score.

MEDICAID	
CMS did not propose changes to the objectives and measures previously established in rulemaking for the Medicaid EHR Incentive Program, and thus eligible professionals participating in that program would continue to report on the objectives and measures under the guidelines and regulations of that program. Accordingly, CMS proposed that reporting on the measures specified for the ACI category cannot be used as a demonstration of meaningful use for the Medicaid EHR Incentive Programs. Similarly, a demonstration of meaningful use in the Medicaid EHR Incentive Programs cannot be used for purposes of reporting under MIPS.	CMS is finalizing its Medicaid policy as proposed. CMS issued a reminder that while MIPS eligible clinicians would be required to meet the requirements of the ACI to earn points toward their MIPS final score, there is no longer a requirement that eligible professionals demonstrate meaningful use under the Medicaid EHR incentive program as a way to avoid the Medicare EHR payment adjustments. However, MIPS eligible clinicians who meet the Medicaid EHR Incentive Program eligibility requirements are encouraged to additionally participate in the Medicaid EHR Incentive Program to be eligible for Medicaid incentive payments through program year 2021.
ACI OBJECTIVES AND MEASURE	
	MIPS eligible clinicians can use an interactive tool on the Quality Payment Program website for viewing and determining which measures to report for 2017. https://qpp.cms.gov/measures/aci