What you need to know about MACRA

MACRA (Medicare Access and CHIP Reauthorization Act of 2015)

MACRA is the bipartisan act passed by Congress in 2015 that moves Medicare from a fee-for-performance model to a value-based payment program in 2017. There will be no new funding for Medicare but rather existing funds will be apportioned to providers based on performance.

The result of MACRA legislation is the Quality Payment Program, known as QPP.

Quality Payment Program (QPP) has 2 tracks:

Track 1: Advanced Alternative Payment Models (APMs)
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment. For information on the Advanced Alternative Payment Models and the Quality Payment Program visit: qpp.cms.gov

Track 2: MIPS (Merit-based Incentive Payment system)
If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS. ***Most behavioral health clinicians will be reporting on MIPS if they meet the Medicare threshold.***

What is the MIPS Medicare threshold requirement? Clinicians must bill Medicare more than $ 30,000 annually **AND** provide care for more than 100 Medicare patients per year. If 2017 is the first year a clinician participates in Medicare, the clinician is not required to participate in MIPS.

What clinicians are required to report in 2017 & 2018?
Physician, Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist who meet the above Medicare threshold. MIPS reporting is optional for hospital-based clinicians in 2017.

What does MIPS mean to clinicians?
You need to report on some MIPS components in 2017 to avoid a 4% reduction of payments in 2019. To obtain the highest reimbursement you should report on at least 90 days and, if possible, all of 2017.

How do I get started in ICANotes?

1) Ask ICANotes Staff to enable the following for customers who want to report on MIPS/MACRA:
MU Measures, Patient Portal Sync, Direct Messaging, Always Generate CCDA – Click here to open a Support ticket

2) Go to your Chart Room and open the Settings & Directories drawer.
Select Options → Specific to Individual:
Check Patient Specific Education AND Clinical Decision Support Rules

What does MIPS consist of?
Four categories are listed below. Clinicians will receive a score for each category except Cost, and a total score for all categories**.** In 2017 to avoid a Medicare payment penalty of 4% in 2019, you can do a very minimal **"test"** report.

MIPS Categories

- **Quality** (formerly PQRS)
- **Advancing Care Information** (formerly Meaningful Use for Medicare)
- **Improvement Activity** (a new category)
- **Cost** (no reporting required for 2017)

Quality	Improvement Activities	Advancing Care Information	Cost
Replaces PQRS.	New category.	Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.

See below from the CMS website: https://qpp.cms.gov

MIPS Overview

Use this tool to browse the different MIPS measures and activities.

Category	What do you need to do?
Quality Replaces the Physician Quality Reporting System (PQRS).	**Most participants:** Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days. **Groups using the web interface:** Report 15 quality measures for a full year. **Groups in APMs qualifying for special scoring 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 MIPS quality.
Improvement Activities New category.	**Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days. **Groups with 15 or fewer 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 receive points 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, the assigned score will be at least half credit.

How will actual reporting be done?

- **Quality Measures** – (formerly PQRS) will be reported via Medicare claims in ICANotes (or for a fee you can use a Qualified Clinical Data Registry).

- **Advancing Care Information (ACI)** - will be calculated through ICANotes reports. You will need to ask ICANotes to turn on settings for this. At the beginning of 2018, you will attest using the data from ICANotes reports for Advancing Care Information.

- **Improvement Activities –** you will keep track of these in your practice. Then you will attest using this data to CMS at the beginning of 2018.

- **Cost** – no reporting on your part is required.

Quality Reporting (formerly PQRS) will be 60% of your score in 2017

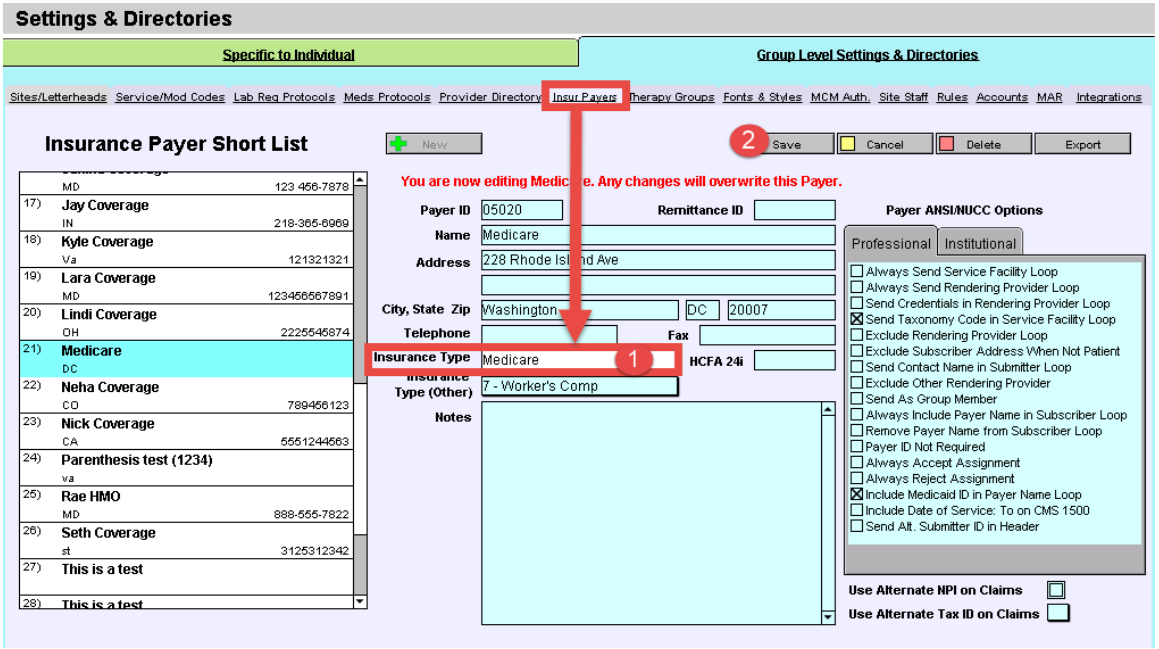
You must report on 6 quality measures.

Report **Quality Measures via Medicare Claims reporting OR a Qualified Registry**. Select only measures that are reportable via claims if you are reporting via claims.

Report on 50% of Medicare Part B patients for which the measure is relevant for 90 days or as many days as possible.

For claims reporting in ICANotes:
Turn on **Medicare** in **Settings & Directories→ Group Level Settings → Insurance Payers→ Insurance Type:**

Quality Measures (formerly PQRS) Setup in Settings & Directories:
Insurance Type has to be set to "Medicare" in order for ICANotes to place the codes onto the claim. It's a very easy fix if this has not been set up before. The user just needs to populate the Insurance Type and click the "Save" button at the top. The program will prompt them to update all patient charts with this insurance and any claims they prep and submit will start to include those PQRS codes. If you need help with this setup, contact Support 443-569-8778 or email ticket@icanotes.com.



What if I don't bill through ICANotes? Can I have a billing report run to use with my billing organization?

Yes. Quality (formerly PQRS) codes have been added to the Billing Report (Columns). Activation of this reporting feature requires a small one-time setup fee. Please contact Sales at 866-847-3590 for activation.

Only certain quality measures can be reported via claims. If possible, report on 90 days or the entire year to ensure you get the highest score.

A clinician must report on 6 MIPS quality measures, one of which should be an outcome measure. If there is no relevant outcome measure, the clinician should report a measure from one of these "high priority" areas – 1) appropriate use, 2) patient safety, 3) efficiency, 4) patient experience or 5) care coordination.

Here are the Quality Measures reportable via Claims most relevant for mental/behavioral health:

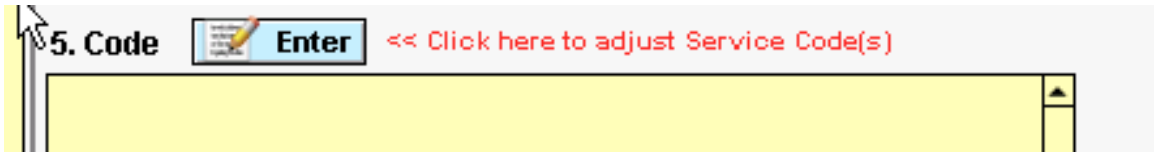
Care Plan, Preventive Care and Screening: BMI Screening and Follow-up, Documentation of Current Medications in the Medical Record, Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan, Elder Maltreatment Screen and Follow-Up Plan, Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, Preventive Care and Screening for High Blood Pressure and Follow-Up Documented (Outcome Measure).

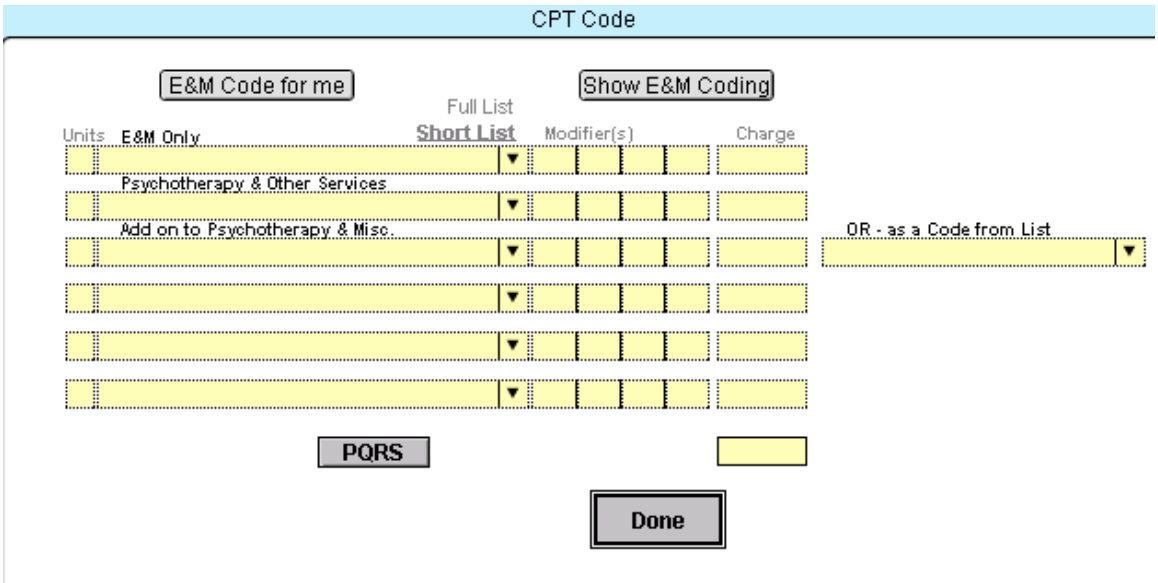
If fewer than 6 measures apply in your practice, report on each measure that is applicable.

Where is the Quality (formerly PQRS) button in ICANotes?

A Quality (formerly PQRS) button is in PN Part 2, Work Area screen, section 5 Code.

Click the **Enter** button as shown below to select claims codes that apply to the session. Quality codes will be included on the HCFA, although there is a limit of 6 codes (including all service codes) per HCFA. See how to access the relevant Quality codes in the screenshots that follow.



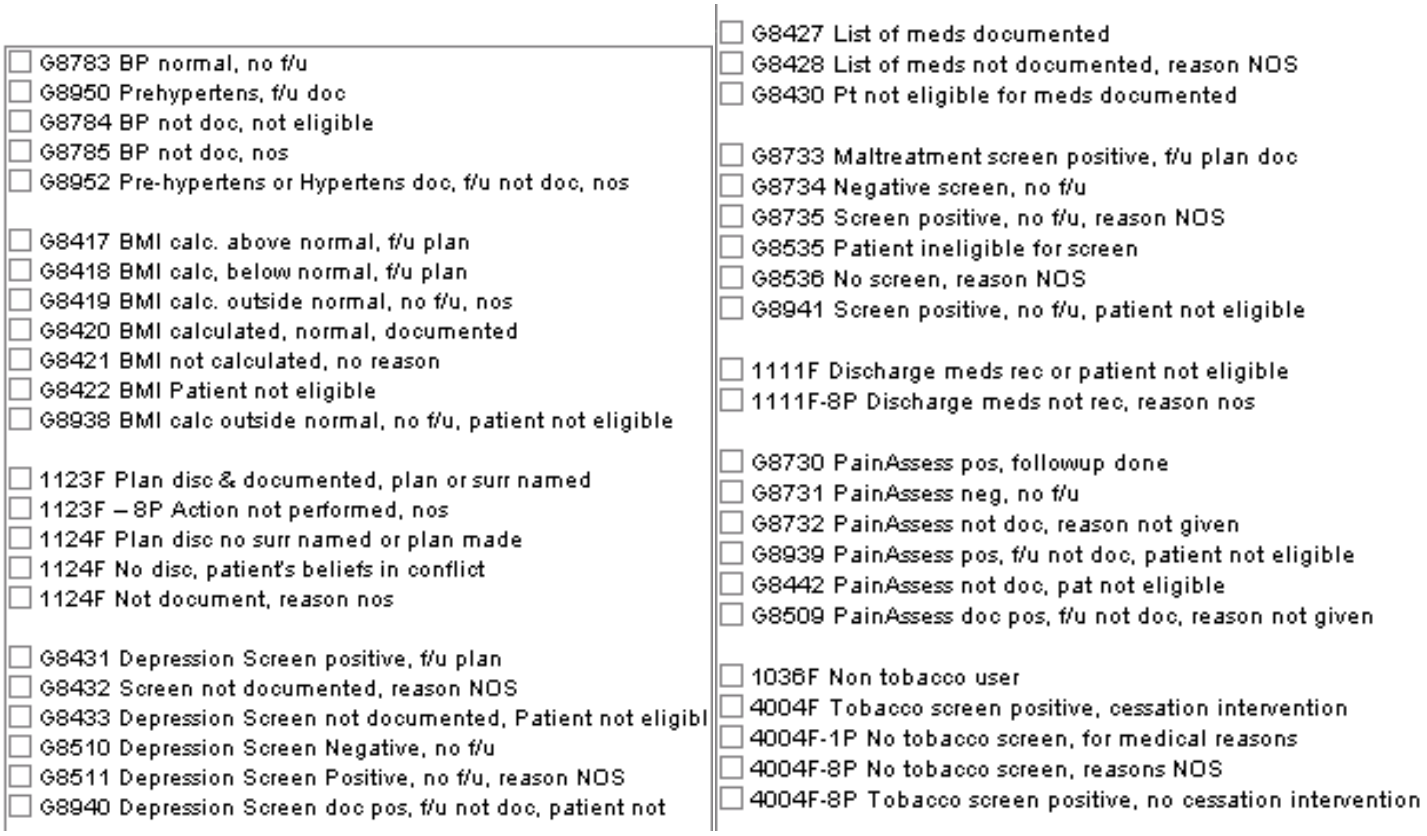


Quality Codes 2017 Behavioral Health Claims-Based Measures

The measures listed below are most relevant to behavioral health for submission via claims-based reporting.

- Medication Reconciliation Post-Discharge (Measure # 46)
- Care Plan (Measure # 47)
- Preventive Care and Screening: BMI Screening and Follow Up (Measure # 128)
- Documentation of Current Medications in the Medical Record (Measure # 130)
- Pain Assessment and Follow-Up (Measure # 131)
- Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan (Measure # 134)
- Elder Maltreatment Screen and Follow-Up Plan (Measure # 181)
- Preventive Care and Screening: Tobacco use assessment and tobacco cessation intervention (Measure # 226)
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (Measure # 317) *Outcome Measure*

Codes available in ICANotes to report on claims for these measures are as follows:



Advancing Care Information – ACI (formerly Medicare Meaningful Use) 25% of your total score

ICANotes was certified for Meaningful Use in 2014, so the 2017 ACI Transition Measures and Scores applies.

Advancing Care Information (ACI) has two scores: a Base Score (50 points) and a Performance Score which, when added together, result in a potential maximum score of 100 points for the ACI category.

Failure to report on the objectives in the Base score will result in a 0 for the overall category. After the Base score has been achieved, a clinician can earn extra points through the Performance score.

The Performance Score is based on Patient Electronic Access, Coordination of Care through Patient Engagement and Health Information Exchange objectives, and the measures shown below.

Bonus Points will be awarded for improvement activities that utilize CEHRT (ICANotes is CEHRT) and for reporting to a public health or clinical data registry. Even reporting "null" concerning public health or clinical data registry should earn a bonus point.

Receive 50 points for Base score.
Additional 80 points for performance
Public health registry – reporting optional, earn 1 bonus point
Full credit for Advancing Care = 100 points
First report Base Measures listed below through attestation or qualified registry. You must be a user of Certified EHR Technology such as ICANotes. ICANotes will generate the reports for all except Protect Electronic health information:

Base Score for ACI Counts for 50 possible points. You must achieve at least a Base Score otherwise the total ACI score will be zero.

How many ACI objectives do I need to report on?

The ACI category requires that eligible clinicians report on a minimum of 4 objectives for the Base Score. If you don't meet the requirements for reporting on all 4 base objectives, you won't get any Base score and you won't be able to earn Performance Score.

- Review the ACI measures available from the 2017 Advancing Care Information Transition Objectives & Measures https://qpp.cms.gov/measures/aci. Remember, in order to get minimum credit for Advancing Care Information, you must at least submit information for the Base measures.
- No thresholds are required for Advancing Care Information but at least 1 in numerator and denominator is required for minimum scoring and yes/no for Security Risk Analysis.
- Download a CSV file of the measures for your records.

Base Score: A minimum of these 4 measures based on ICANotes 2014 CEHRT certification:

1) **Security Risk Analysis** (Protect Patient Health Information) Yes/No statement This is **not** an ICANotes report. You do this within your practice.

   Resources for Security Risk Analysis:
   https://www.healthit.gov/providers-professionals/security-risk-assessment-tool
   https://www.healthit.gov/providers-professionals/security-risk-assessment-videos
   https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016_SecurityRiskAnalysis.pdf

2) **ePrescribing** (Electronic Prescribing) You must use ePrescribing. Report Numerator/Denominator

3) **Patient Electronic Access** (Provide Patient Access to view online, download and transmit.) Report Numerator/Denominator

4) **Health Information Exchange**: (Use ICANotes to create a summary of care record & electronically transmit summary to a receiving health care clinician.) Report Numerator/Denominator

Performance Score: This is in addition to the Base Score for the Advancing Care Information (ACI). You need to earn up to 50 more points to receive the maximum score of 100 points.

Once clinicians earn the required 50 points for the Base Score for ACI, they can earn additional points in the Performance Score.

The Performance Score is based upon performance on these objectives: Patient Electronic Access, Coordination of Care Through Patient Engagement, and Health Information Exchange objectives.

How is the "Performance Score" calculated?

The performance score is comprised of your scores on the following 7 measures:

- **Provide Patient Access** (worth up to 20% or 20 points if you report on more than the base score). Patient views, downloads or transmits their health information.

- **Health Information Exchange** (worth up to 20% or 20 points if you report on more than the base score). Create a summary of care record and electronically transmit the summary of care record.

- **View, Download or Transmit** (VDT) (worth up to 10 points)

- **Patient-Specific Education** (worth up to 10 points). Identify patient-specific educational resources and provide electronic access to those materials to at least one unique patient.

- **Secure Messaging** (worth up to 10 points). A secure message was sent to the patient or in response to a message sent by the patient

- **Medication Reconciliation** (worth up to 10 points). Perform Medication Reconciliation for at least one transition of care.

- **Immunization Registry Reporting** (worth up to 10 points). *Public Health and clinical data registry reporting objective: immunization registry reporting, specialized registry reporting, syndromic surveillance reporting measure – report "null" if you do not provide immunizations.*

Your performance rate on each measure is transformed into percentages toward the overall category score as follows: You can earn up to 20 points on the first two measures, and then up to 10 points on each of the other 5 measures, up to a maximum of 90% on the performance score. Reporting is optional for each of the other 5 measures, so you'll only be evaluated on your performance if you report for a measure.

Only 50 Performance Score points are needed, to add to the 50 Base Score points, to achieve the 100 total points needed for full credit in the MIPS ACI category.

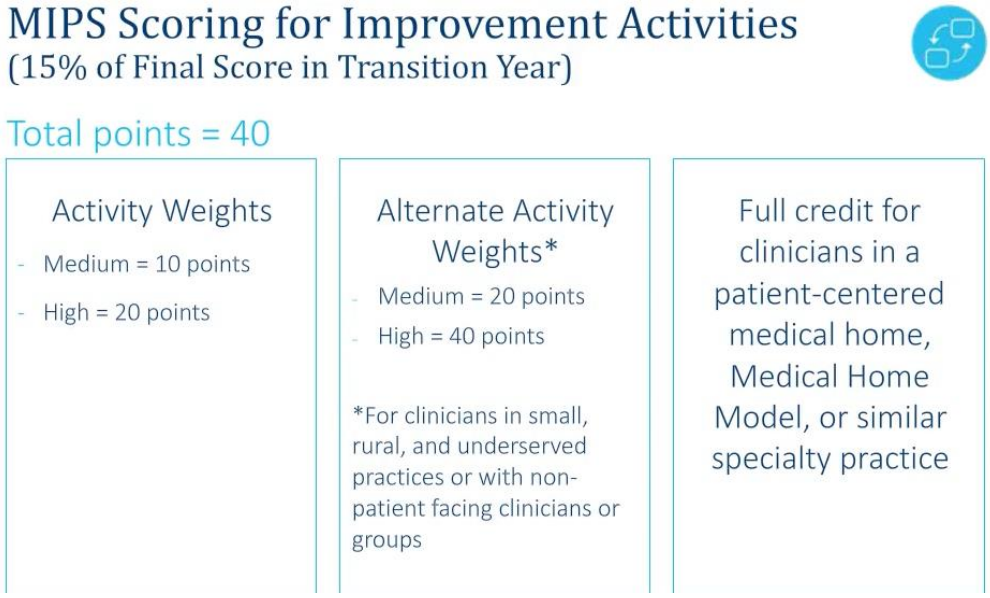
In addition to percentages earned on the base and performance scores, you're able to get bonus points in two ways. First, reporting for any of the following registry reporting measures will result in a bonus of 5%:

• Syndromic Surveillance Reporting
• Specialized Registry Reporting

Improvement Activities (New category) 15% of your total score in 2017

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

To achieve full credit, a clinician must report on **four medium-weighted or two high-weighted activities for a minimum of 90 days**. This will earn the clinician 40 points for a 100% score on Improvement Activities.



For small practices, rural practices or practices located in geographic health professional shortage areas to **one high-weighted or two medium-weighted activities**.

Important: Keep track in your practice of the Improvement Activities you perform.

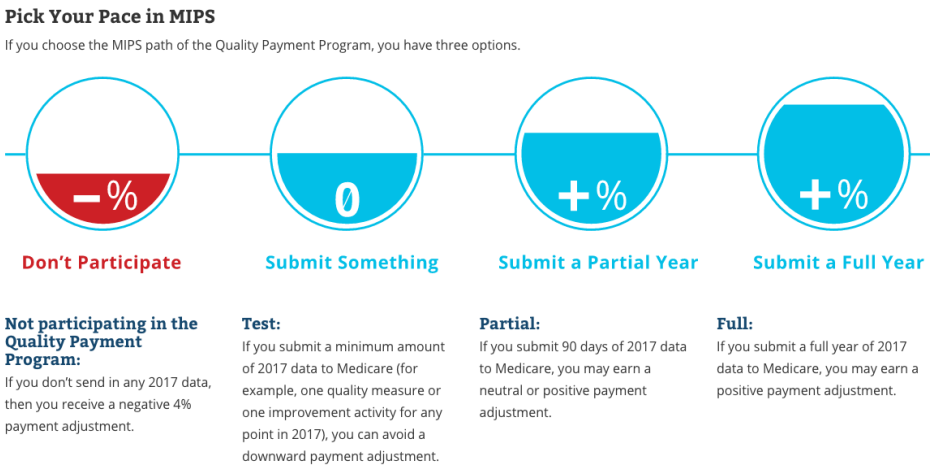
Improvement Activities definitions and their weights can be found at:
https://qpp.cms.gov/measures/ia

Some that may be of interest to behavioral health clinicians include:

Depression Screening, Electronic Health Record Enhancements for Behavioral Health data capture, Engagement of new Medicaid Patients and follow-up, Tobacco Use, Unhealthy alcohol use, Engagement of patients, family and caregivers in developing a plan of care.

Cost Category – No scoring or reporting required for 2017

How can I avoid a payment adjustment?
In 2017 to avoid a Medicare payment penalty of 4% in 2019, you can do a very minimal **"test"** report.



What would this MIPS "TEST" report consist of?

In 2017 report on:
1 **Quality measure for 1 patient** (formerly called PQRS) submitted via claims or qualified registry at any time during 2017.

Only measures that allow submission via claims reporting can be reported via claims. Some behavioral health related measures cannot be submitted via claims.

Information about Quality Measures can be found at:
https://psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/payment-reform/toolkit/quality-performance-category

OR
5 required **Advancing Care Information** objectives (formerly called Meaningful Use measures) submitted via attestation to a CMS portal in early 2018. ICANotes is a certified EHR (CEHRT) and you can use ICANotes to capture numerator and denominators on some of these required measures.

Information about the Advancing Care Information can be found at:
https://psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/payment-reform/toolkit/advancing-care-information-performance-category

OR
1 **Improvement Activity** (a new category) - you keep a record within your practice and attest to having done the activity via CMS portal in early 2018. Samples of Improvement Activities can be found at:
https://psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/payment-reform/toolkit/improvement-activities-performance-category

If you do send data via this test report, you would not earn an incentive but there would be no penalty in 2019.

How could you earn an incentive via MIPS?

You can do at least 90 days of reporting starting any time between January 1 – October 2, 2017 and you might earn a small positive payment adjustment.

If you report on more than 90 days or an entire year in 2017, you might earn a larger adjustment.

The finalized scoring methodology has a unified approach across all performance categories, which will help MIPS-eligible clinicians understand in advance what they need to do in order to perform well in MIPS. The three performance category scores (quality, improvement activities, and advancing care information) will be aggregated into a final score. The final score will be compared against a MIPS performance threshold of 3 points. The final score will be used to determine whether a MIPS eligible clinician receives an upward MIPS payment adjustment, no MIPS adjustment, or a downward MIPS payment adjustment as appropriate.

The final score will also be used to determine whether a MIPS eligible clinician qualifies for an additional positive adjustment factor for exceptional performance. The performance threshold will be set at 3 points for the transition year, such that clinicians engaged in the program who successfully report one quality measure can avoid a downward adjustment. MIPS eligible clinicians submitting additional data for one or more of the three performance categories for at least a full 90-day period may qualify for varying levels of positive adjustments.

CMS has said the MIPS payment adjustment is based on data submitted. The best way to get the maximum adjustment is to participate for a full year.

BUT if you report for 90 days you could still earn the max adjustment based on your score.

Positive adjustments are based on the performance data submitted, not the amount of information or length of time submitted.

ICANotes is a CEHRT – a Certified Electronic Health Record Technology - and using a CEHRT is required for reporting on **Advancing Care Information** measures (formerly Meaningful Use measures).

Where can I find help?
https://qpp.cms.gov is the website that CMS will update regularly.
A CMS fact sheet can be found at:
https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf

CMS Help Desk for Quality Payment Program: send an email to qpp@cms.hhs.gov or call 1-866-288-8292, Monday-Friday 8 am – 8 pm Eastern time.

American Psychiatric Association has information including webinars at:
Payment Reform Toolkit
https://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/payment-reform

How will ICANotes help?
If you wish to ask an ICANotes-related question you can send an email to macra@icanotes.com