MACRA: MIPS Track

PICK YOUR PACE
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This Supplementary Document is designed to help guide Eligible Professionals as to the options available in participating in MIPS along with related ramifications.

**REPORTING OPTIONS**

1. **Individual Reporting**
   If reporting individually, the eligible clinician will be assessed at the TIN/NPI-level across the MIPS performance categories.
   The provider would be assessed across all 4 MIPS performance categories accordingly.

   - **Exempt if:**
     - Provider bills less than $30K in Medicare Part B allowed charges during a calendar year.
     - or
     - Provider sees less than 100 Medicare Part B patients during a calendar year.
     - or
     - Enrolled in Medicare for the first time during the performance period (exempt until following performance year).

2. **Group Reporting**
   A group, as defined by Taxpayer Identification Number (TIN), would be assessed as a group practice across all 4 MIPS performance categories.
   If 1 provider submits data for the entire group that is sufficient for all within the group.
   The more data that’s reported, the better score you may receive and therefore a better payment adjustment (the more providers that actively participate the better).
Each eligible clinician participating in MIPS via a group will receive a payment adjustment based on the group’s performance.

**Exempt if:**
- Group bills less than $30K in Medicare Part B allowed charges during a calendar year.
  - or
- Group sees less than 100 Medicare Part B patients during a calendar year.

**REPORTING REQUIREMENTS OVERVIEW**

1. **Submit Something** (Avoid 4% penalty)
   - a. **Improvement Activity**
     - Providers must report 1 Improvement Activity
       - or
   - b. **Quality Measures**
     - Providers must report 1 Quality Measure
       - or
   - c. **Advanced Care Information**
     - EPs must meet the following:
       - Receive a 50% base score in Advancing Care Information
       - *Required base measures for a 2014 CEHRT are as follows:
         1. Security Risk Analysis
         2. E-Prescribing
         3. Provide Patient Access
         4. Health Information Exchange

*Please Note*: These objective requirements are for the 2017 Advancing Care Information Transition Objectives and Measures. CareCloud is a 2014 CEHRT and follows this Advancing Care track.

2. **Submit at Least 90 Days** (Avoid penalty, and earn a potential incentive)
   - a. **Quality Measure**
     - Most participants
       - 6 Quality Measures (including an outcome measure or another high priority measure if an outcome measure is not available)
       - or
       - 1 Specialty-Specific Measure Set
• **ADDITIONAL INFORMATION**
  
  • EACH Quality Measure has to pass the following criteria in order to be compared to that Measure’s Benchmark which will determine how many points they get for the Measure.
    
    1) Data Completeness Rate must be 50%, or higher.
    2) Performance Rate has to be greater than “0”.
    3) They must have 20, or more, patient encounters in the Numerator of the Measure.
  
  • If the Measure meets all 3 criteria then the Performance Rate of that Measure will be compared to the Benchmark and points will be rewarded depending on which Decile Range the percentage lands in.
  
  • Each Measure is worth 3 -10 Points and CMS will utilize the 6 Highest Scoring Measures (if one of them includes the required Outcome Measure) to determine their Quality Measures Score.
  
  • Bonus points can be earned by Reporting additional Outcome Measures (2 points each) or additional High-Priority Measures (1 point each) up to a Maximum of 6 points for this Bonus.

  • The Maximum points that can be scored for the Quality Category is 60 points which will go towards the final MIPS Score.
  
  • *PQRS Benchmark information available via the QPP website ([https://qpp.cms.gov/docs/QPP_Quality_Benchmarks_Overview.zip](https://qpp.cms.gov/docs/QPP_Quality_Benchmarks_Overview.zip)).

**b. Improvement Measures**

• Individual Providers and Groups less than 15 Providers must submit the following Improvement Measures:
  
  • 1 high Improvement Measure
    or
  
  • 2 medium Improvement Measures

• Groups with 15 or more Providers must submit the following Improvement Measures:
  
  • 2 high Improvement Measures
    or
  
  • 1 high and 2 medium Improvement Measures
    or
  
  • 4 medium improvement Measures
c. Advancing Care Information
   • EPs must meet the following:
     • The required measures for meeting the Base and Performance Scores are as follows (select up to 7 measures):
       1) e-Prescribing (required) -------------------------------  At least 1
       2) Health Information Exchange (required) --------  Up to 20%
       3) Provide Patient Access (required) -----------------  Up to 20%
       4) Security Risk Analysis (required) -------------------   NA
       5) Immunization Registry Reporting--------------------- 0 or 10%
       6) Medication Reconciliation--------------------------- Up to 10%
       7) Patient-Specific Education---------------------------- Up to 10%
       8) Secure Messaging------------------------------------ Up to 10%
       9) View, Download, or Transmit (VDT)------------------ Up to 10%
     • A bonus score of 10% can be earned by reporting Improvement Activities that are tied to Advancing Care Information Measures.

• Flexibility
  • CMS will automatically reweight the Advancing Care Information performance category to zero for Hospital based MIPS clinicians, clinicians with lack of Face to Face Patient Interaction, NP, PA, CRNAs and CNS.
  or
  • If clinician faces a significant hardship and is unable to report advancing care information measures, they can apply to have their performance category score weighted to zero.

3. Submit a Full Year (Avoid penalty, and earn a potential incentive)
   a. Follows the same requirements of 90 days, but data must be submitted for the entire year.

REPORTING METHOD(S) OVERVIEW (CARECLOUD PREFERRED)

1. Quality Measures
   • Claims (via CareCloud System)
     • Reporting via claims is not accepted if reporting as a group.
   • Qualified Registry (via 3rd Party Vendor)

2. Improvement Activity
   • Attestation

3. Advanced Care Information
   • Attestation
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