Advancing Care Information: Tips, Tools, and Support
Transcript from Live Webinar

Wednesday, March 29, 2017

Laurie Fink: Good afternoon and welcome to today's webinar, Advancing Care Information: Tips, Tools, and Support. My name is Laurie Fink and I am the Quality Insights Communication Specialist for the MACRA/MIPS initiative. We will get started with today's program in just a few moments, but first, a few housekeeping items. All participants entered today's webinar in a listen only mode. Should you have a question during today's presentation we ask that you please type it into either the chat or the Q&A box to the right of your screen. We do have members of the MACRA/MIPS team on the webinar today and they will be answering your questions as they are submitted.

If we do not get to all of them we will do a brief Q&A following the presentation. Today's webinar is being recorded. The recording along with a copy of the slide deck will be posted on the Quality Insights website at www.qualityinsights-qin.org. Both resources can be found by clicking on the events tab and then selecting the archived events option. I will go ahead and post a link to that page in the chat for your convenience. A copy of the slide deck was emailed to everyone who registered to attend this event prior to 11:00 a.m. this morning. If you registered after that you can just go to the Quality Insights website, as I mentioned before, and the slide deck will be posted there.

At this time I will now hand the presentation over to our speaker, Kathy Wild. Kathy is the Quality Insights MACRA/MIPS Network Task Lead. Kathy.

Kathy Wild: Thank you, Laurie, and welcome everyone on this beautiful sunny spring day. Today we're going to talk about the Advancing Care Information category of MIPS. Hopefully, I can provide you with some tips, a new tool which we are going to be sending out later this week and offering you the support to help you, hopefully, achieve the full credit and maximum points in the Advancing Care Information category. After today, hopefully, you will understand how the Advancing Care Information measures are scored differently than they were for the Meaningful Use Program. Also, you will learn how to understand how the Advancing Care Information category impacts the MIPS score in general. And also, we definitely want to help you learn how to improve your ACI performance rate so that you can receive full credit for the ACI category.

What's new in 2017? First, I'm going to give you a couple slides with just a very high level overview of the Quality Payment Program. I'm sure by now, the first quarter of this year is almost over, you probably have already attended at least one Quality Payment Program presentation in the past, so some of this might be repetitive but I just want to throw it out there and tie it into just this category. As we know, on December 31, Medicare programs ended for the EHR Incentive Program, which was Meaningful Use. Everyone had to attest by March 13 and right now the hardship application exceptions can be submitted up through July 1, if you were unable to meet Meaningful Use in 2016 and if you feel that one of the categories does qualify for you.

Please note that it is not the same as in 2015, when CMS pretty much offered a blanket exception for everybody and that was due to the late release of the final rule. In 2015 there was a lot of changes with Meaningful Use, so this time you will have to provide some information as to why you feel you qualify for that exception and then you will not get the 3% penalty in 2018 for not meeting Meaningful Use in 2016. The PQRS Program also ended on December 31 and everyone has 48 hours with March 31 as the deadline to submit those final PQRS measures. And that also ties in with the Value Based Modifier.

What happened beginning January 1 of 2017 is the initiation of the Quality Payment Program which contains two tracks; the Merit-based Incentive Payment System, with an acronym of MIPS, and then you probably also know the other track is called the Advanced Alternative Payment Models, and those are called APMs. Basically, we are changing and all reimbursement will be based on value with incentive to improve quality of care for all patients. Here's just a little diagram, and you've probably seen this before, showing you the two tracks. Since over 95% of clinicians are probably going to be reporting in the MIPS Program, that's what the focus of today's webinar will be on.

Specifically that in MIPS, clinicians and groups can go ahead and submit measures that they want to from a choice of three different categories, and then their Medicare Part B reimbursement rate in 2019, which is two years from now, will be based on the performance rates for the measures that they submit. The other model track for the Quality Payment Program is Advanced APMs have to do with people that are in Medicare Shared Savings Programs, certain ACOs, and they are rewarded differently, so that they can avoid the MIPS penalties. And just as a sidebar that CMS did update the QPP website on March 17 and they provided an updated list of APMs, so you can definitely check that out if you care contemplating joining one of those. It will be under the education and tools section on the QPP website.

Okay, one of the things for MIPS, when you decide to report, is whether you're going to do that as an individual or do group reporting. A group is defined as two or more clinicians, so unless you're a solo practitioner you will have to make this decision. And it's something that does not just involve this Advancing Care Information category that we're talking about today. The reason is that for all three different categories, which are the Quality category, the Advancing Care

Information category, and the Improvement Activity category, all three must be reported at the same level, meaning that you're either going to provide data at the clinician level for all three of those categories if you want to report all three or you're going to do it at the group level.

If you are in an ACO, you do have to report the Advancing Care Information measures at the group level and the reason for that is because your quality measures will automatically be submitted to CMS at the group level, therefore everything has to be at the group level. That's one of the first things that you need to decide, how you're going to report. Okay, so let's talk briefly what is the MIPS score. I compare it to the grade point average you had when you were a high school student. You received a report card and each one had grades for each subject. For 2017 there are three subjects or categories that CMS is going to grade clinicians on. One is the Quality category, one is Advancing Care Information, and one is improvement activity.

And they're making it simple. The total score that you can get is 100 points and what they're going to do is add the points from each of those three categories together to see what your score is. Now, the thing is they measure each category with a different weight. Let's see, that is on the next slide.

Okay, so the Quality category, and you can see it's worth 60 points which is more than half of your score, therefore it is really important to look to make that selection, figure out how you're going to submit those measures, and really focus on them because they have a huge impact on your MIPS score this year. We are having a webinar on April the 19th, specifically to go over the Quality category, so stay tuned for that.

The Improvement Activity is worth 15 points of your total MIPS score, 15 out of 100, and we recently had a webinar on March the 14th, and you can find the recording and slides for that on our website under the events section. And then the Advancing Care Information, which we're talking about today, you can see is worth a quarter, which is 25 points out of the total score. These are the relative weights, the default rates, but please know and you'll see during some subsequent slides that the weights are adjusted in certain circumstances. Also note that the weights that are on this screen only reflect 2017 score.

Every year CMS releases new legislation, new rules and regulations and the weight of these categories is going to change every year. Especially next year when they add in the fourth category of cost, all of them will have to get re-weighted, so that you are dividing that 100 points into four categories instead of three. But this is what we're looking at for this year. One thing that CMS has done is they want to be very fair to everybody, so because this is a brand new program, it's called a transition year, and they want providers to have the right to pick their pace. If a provider does not participate at all, report zero measures, then they will automatically receive a -4% payment adjustment in 2019 and just remember the payment adjustments reflect what was done two years prior.

The reason for that is CMS needs that one year in between to collect the data, review it, make the analysis, and then implement the changes so when January 1 of 2019 hits those payment adjustments will automatically be applied. There'd be no way for them to do adjustments on January 1, '18 when you haven't even submitted the data yet. If you want a neutral or a small positive payment adjustment for this year all you have to do is submit one measure in one of those three categories. If you submit data for 90 days for more than one measure, it could be in one category, two, or all three, you can expect a smaller positive payment adjustment.

And then, of course, if you want to submit data for a longer period of time and for all of the measures, you have the greatest opportunity to receive a higher payment adjustment. Okay, so MIPS eligible clinicians in 2017, and you've probably seen this before, includes not only the physicians but also PAs, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. What you have to know is that the other clinicians here would only be included if they do bill using their own NPI number, so if you have a nurse practitioner or PA in your office but they bill using your physician's NPI, then they would not be counted or scored or anything like that.

One of the things to also be eligible is that the clinician must bill Medicare Part B for more than $30,000 a year and see more than 100 Medicare patients per year. If you're under that, if you have either one, then you aren't eligible which means that you would not have that penalty applied to you. And one thing to note is that this program does include non-patient facing clinicians. Some examples are pathologists, radiologists, anesthesiologists, and nuclear medicine. CMS, in the final rule they did give us a definition of a non-patient facing clinician, so for an individual it's one who bills 100, it should be less than or equal to 100 patient facing encounters, including Medicare telehealth services during one of the determination periods.

And then a group would be when more than 75% of the MPIs billing under that can meet the definition of an individual non-patient facing clinician. CMS is going to make the determination and what they'll do is they'll actually look at claims data. They will have two determination periods to identify them. The first period has ended, which was September 1 of 2015 through August 31 of 2016. And then, at the end of August this year they'll go ahead and look at claims based on the previous 12 months and find those clinicians that would also have those, and then they would automatically know that these are non-patient facing clinicians. This means they still participate in MIPS, but they have the opportunity for different scoring that you'll see.

Some optional clinicians, now we're going to dive into the Advancing Care Information. That was just a brief overview of MIPS in general. For Advancing Care Information, which is basically replacing the Meaningful Use program in previous years, there are some new clinicians that did not have an opportunity to participate in the Medicare program and these are the nurse practitioners, PAs, nurse specialists, and you can see the list there. Now, the Medicaid EHR

Incentive Program did allow nurse practitioners and PAs that were in a PA led federally qualified health center but for Medicare neither could participate so CMS wants to allow these clinicians an opportunity to get their feet wet and see what's going on but they don't actually have to report any of the ACI measures this year.

What will happen is if one of these optional clinicians does not report any ACI measures, CMS will automatically re-weight their category. Remember I said all the categories have to equal 100 points, so if you take away the 25 points from the Advancing Care Information category they will automatically add that to the Quality category. That means for the nurse practitioners, and PAs, and anybody else who does not report any Advancing Care Information measures, their quality score is really going to be important for them to focus on because that's 85% of their MIPS score. If any ACI measure is submitted by one of these optional clinicians, then CMS is going to go ahead and score the data, so if you submit it, they will score it. Just like if you build it, they will come. Just remember that CMS will go ahead and take a look at that data.

One of the things that, as I mentioned for Meaningful Use, is if you didn't meet MU last year right now the hardship applications are open, so it appears that CMS is also going to have some hardship exception applications for Advancing Care Information. And these are going to be based on the following three reasons, insufficient internet activity, extreme and uncontrollable circumstances, such as the flood that Louisiana had not too long ago, Hurricane Sandy in New Jersey, things like that, and then the third reason is loss of control over the availability of certified EHR technology.

An application would have to be submitted and then if CMS does approve that application, CMS will go ahead and re-weight the ACI category to zero but remember that's when they will increase the Quality category weight to 85%. Remember, you don't have to, when you report ACI, if one of these things happens but remember the impact on your MIPS score is that the Quality category is going to be scored a lot higher.

Okay, talking about Certified EHR Technology. The only way you can even participate in this category and/or receive the electronic reporting bonus point for the Quality category, which we will go over on our future webinar, is that you do have to have a certified EHR.

Right now almost everybody is using the 2014 Certified Edition. The 2015 Edition is coming out. Most vendors are making that available now and the reason for that is that as of right now the final rule states that beginning January 1 of 2018, which is nine months away, everybody has to be up and running on the 2015 version if they want to participate in MIPS next year for the ACI category. Just remember that, I'm going to repeat it again, that you do have to upgrade sometime before the end of this year, meaning by December 31. It's a good time now to contact your vendor, see when they'll be upgrading, and

having them available, and getting on their waiting list to go ahead and get that done.

Basically, you can have the 2014 Edition, or use the 2015 Edition or you can have the combination. If you select a reporting period and you upgraded during that time, that is perfectly acceptable, too. Okay, so for this year CMS, instead of dictating one set of measures that everybody has to follow because it's the transition year, they did come up with two sets and the other reason they had to do that is because it will be based on the EHR version that you have. If you have the 2015 version or you've upgraded from 2014 to 2015 during your EHR reporting period, you can use the ACI measures and we're going to go over them in a minute. If you don't have them or you choose not to report that measure set, there is another set called the ACI Transitional Measures.

As far as I know, they're only going to be available this year but, as I said, we won't know that, until the final rule comes out, if everyone will have to use the ACI measures. Option one, the ACI Measures. As I stated, you have to have 2015 CEHRT and that can be accomplished using 2015 Edition during your entire reporting period or a reporting period when you have the upgrade. Remember, for every category you can pick different reporting periods. For Quality, you might want to report Quality measures for the full calendar year. You might want to report in for 233 days. For Advancing Care Information you might want to pick 90 days, you might want to pick 110 days, they don't have to be the same dates, months, anything like that.

Just in each category, they have to be the same but the different categories you have that option to pick differently, so even though everyone has to upgrade this year you might want to pick a reporting period at the beginning of the year and middle of the year, and not at the end when you have already done that upgrade. The ACI measures include five base measures and nine performance measures, and three of these measures are new, which no one has reported before. Option number two, the ACI Transitional Measures can be reported if you have the 2014 EHR version, 2015 or the combination of the two.

This one, you'll see, is more lenient, it has four base measures and only seven performance measures, and the main thing is, all of these measures for everyone that's ever reported Meaningful Use, have been reported before and they're all familiar to you. My thought is that almost everybody, it would behoove you to just go ahead and just select the transition measures that, since you are currently used to reporting those measures, and you don't have to worry about having the upgrade at that time. I just wanted to let you know that during the rest of this presentation I will be going into detail with the transition measures.

If you want more details about the ACI measures please contact us and we can help you. I do have a couple slides and I will allude to the changes with those, however, so you won't be completely in the dark. The ACI Transitional Base Measures, the one thing to know is that even though this is not like the

Meaningful Use Program where in order to meet Meaningful Use it was an all or nothing thing, you had to meet the threshold for all of those measures or you didn't meet Meaningful Use. CMS did not want to do that at all for Advancing Care Information or any of these MIPS measures; however, this is one part where there really is an all or nothing requirement.

The reason is, for the base measures that are the transition measures, there are four of them, you actually do have to meet all four if you want any points in this category. If you do meet all four you'll automatically get 50 points out of the 100 just for this category, and let's go over them. One is the security risk analysis ... Hold on one second here, okay, which the only change about that is that it does have to be done during the calendar year, which means you do have to have it done prior to December 31 of 2017. You can't wait until prior to attestation like you could with Meaningful Use in the past.

And one thing I did want to note for any practices that have utilized Quality Insights staff to perform their privacy and security assessment in the past, we will no longer be able to do that. We've received some other contracts and it's been determined it's a conflict of interest. However, we will be able to assist you in finding help to have that analysis performed. Another thing I want to tell you is on HealthIT.gov, and I have the link here, they do have a security risk assessment tool and if you follow that step-by-step that would also meet the measure of having that measure done. Remember that is a yes/no measure and you have to attest that yes, you have that done.

The other three base measures, you do have to have just a one in the numerator and I'm going to repeat that, a one in the numerator, except for electronic prescribing. Initially, CMS said they would not be allowing any exclusions for Advancing Care Information measures at all and this is the only exception, electronic prescribing. It's a measure that's been in the Meaningful Use Program since its inception and what it says is that if you have to have at least one prescription queried for a drug formulary and transmitted electronically through your EHR. And the reason why CMS just added the exclusion is because it wouldn't be fair to those clinicians who don't write prescriptions, maybe a nurse practitioner doesn’t. A podiatrist is eligible to participate in MIPS. It's very rare when they ever write a prescription, so in order to go ahead and not dismiss them from receiving the ACI points, they had to put this exclusion in so anybody that writes less than 100 prescriptions can claim the exclusion or they can just say, "Yes, I have at least one in the numerator."

Okay, base measure number three is patient electronic access and that measure has been around for a while, where at least one patient seen by the clinician during the performance period is provided timely access to view online, download, and transmit their health information. And basically that means that they have access to a patient portal, is what that boils down to. And just note that the definition for timely access remains the same. It is providing that

information, being available through the patient portal within four business days.

Okay, and then the last base measure, and this is one that I know gives a lot of clinicians a problem, is the health information exchange measure. And what this requires is any clinician that refers or transitions their patient to another provider or another setting of care has to electronically submit that summary of care record to the other clinician or setting. For Meaningful Use, a lot of physicians were able to meet Meaningful Use because there was an exclusion that if you had less than 100 transitions of care you could claim an exclusion, so a lot of doctors haven't worried about this.

Guess what? This year you have to have one, absolutely, or you don't get the base points. And if you don't get the base points you don't get any points in this category at all. If you're an internal med or family practitioner it makes sense, you're going to give information to a specialist that you refer your patients to. However, we work with a lot of specialists, so they're like, "Okay, well I don't usually refer to another specialist." You can still go ahead and send that summary care document back to the primary care provider that referred the patient to you initially and set it up that way, so in your EHR you're still clicking that it's a transition of care, not necessarily a referral for them to follow up but doing it that way.

If you utilize a health information exchange in your state, if that's available, that is one method of doing it. Sometimes some EHRs have internal methods to go ahead and exchange those documents electronically, and then also there's direct messaging if you have a direct email address. I know in some of the states, such as Delaware, we have created a directory so we can share the direct email addresses, so then you'll need to work with your vendor to figure out how to go ahead and do that. I'm just going to repeat again, you have to have at least one summary of care sent electronically if you want any points in the Advancing Care Information category.

The second bullet point I just wanted to go over briefly, is that if we work with large practices, large multi-specialty practices, where you might have some primary care providers, some specialists, maybe even a doctor in a hospital, if they're all under the same TIN, guess what, then it doesn't count. I don't care if the practice is one that's located in one city and one in another, you're still all under the umbrella, the same umbrella and the same EHR, therefore that does not count. It has to be to an outside organization. Okay, so those were our four base measures.

For the transition measures, there are seven of them, six of them involve numerators and denominators, and then the last one is immunization registry reporting. We're going to go through them one by one. And once again, these are ones that, if you participated in Meaningful Use, then they will be familiar.

How are the performance measures scored? This is where it varies from Meaningful Use, where you had to meet a threshold and then if you met all the thresholds you met Meaningful Use. Okay, so now instead of just looking at that data and submitting numbers to CMS, you are going to get paid and reimbursed based on your performance rates. The score for each of these measures is actually going to be determined by your performance rate which is basically looking at your dashboard report, whatever kind of report your EHR gives you with the numerators and denominators.

Most measures are worth 10 points, okay, so that's four of them are worth 10 points but there are two measures that are worth 20 points, and that's only in this transition measure set. If you report the ACI measures all of them are worth 10 points. CMS is giving credit to clinicians that do really well with the patient electronic access, meaning that a lot of their patients are on the portal, you'll get a lot of points, and the more that you exchange summary of care records with other providers the more points you'll get also. Immunization registry, that's just a yes or no, meaning you are going to get 10 points, which is maximum credit for a measure if you do report there, if you do not you will not get any points for that measure.

The maximum points for the performance measures is 90 and that's because two measures are worth 20 so that would be 40, and then the other measures are worth 10, so when you add them all up for the seven you get 90. And this shows you how CMS converts the points that you get when looking at your Meaningful Use dashboard report, depending on what your performance rate is how many points you would get for that measure. As I said, these four measures view/download/transmit, patient ed, secure messaging, and med rec are only worth a maximum of 10 points but the patient portal and the health information exchange are worth 20 points, so there's a little table that helps you show that.

Okay, so the first performance measure is the patient electronic access, which is having the patient portal. And as I said, the maximum number of points for this measure is 20 points. The second performance measure is information exchange, which is also one of the base measures that we've talked about, the summary of care. Basically, you only have to have one but if you have more then you're going to have a higher performance rate and we'll show you how that impacts your score at the end.

The third performance measure is view/download/ transmit, which means that at least one patient seen during the performance period actually goes online and views, or downloads, or transmits some of their health information, so if they access the portal it will get counted. The maximum number of points for this measure is 10 points and this is one of the measures where I say that the physician is really being scored on what the patient does and you can't really give a lot of tips to the provider and the practice on how to improve this rate because it's really based on what the patient does. All you can do is, I don't want

to say nag the patients, but encourage them to use it more often, is the only way to really get this rate to be higher.

The fourth performance measure for this measure set is patient education, which is the same measure that's been in Meaningful Use. The maximum number of points for this measure is also 10 and I think since most clinicians have been doing this for a while they should have a high performance rate in this category.

One of the things I did want to note is that beginning next year for that Advancing Care Information measure set, not this transition one, CMS changed the wording and all educational materials must be accessed electronically, so that's the difference between the other measure set and this measure set, which means that it has to be through the portal, whether it's posted on the portal or sent electronically with a message. However, right now you can still go ahead and print off something and hand it to the patient and you'll still get credit for this measure. And every vendor's different as to what you exactly have to check off in your EHR, so that's an individual thing but everyone will have to be electronic for the ACI measure set for next year.

Okay, we're up to measure number five performance measure, secure messaging and this measure has been around for a couple of years now for Meaningful Use. CMS did allow the flexibility that the secure message can be either sent by the clinician to the patient or by the patient to the clinician. It doesn't matter who initiates it, as long as it's done. The maximum number of points for this performance measure is 10 points and what I say is that I think everyone can get full credit for this if the practice is able to send a mass email to everybody that's enrolled in the portal, sending some type of message. Maybe if you give flu shots at the beginning of flu season, if that's going to be your performance period, send a message out that way. Otherwise, send a general message saying, "Hi, we are sending this to you via the portal. We want you to know what the importance of that is. You can see your lab results here, you can do X, Y, and Z". If you do some kind of mass messaging, then you would have 100% compliance rate for this measure," so it's one thing to think about.

Okay, the sixth performance measure is medication reconciliation. That has also been around for many years for Meaningful Use. It involves transitions of care so that whenever a patient comes in that was seen in a different setting, or by a specialist, or another clinician, you're supposed to reconcile the meds. I think what we've always told physicians in the past with Meaningful Use is that, med rec is so important, so why not do it with every patient during every office visit?

It's something that you should always review for them. Really clinicians should have 100% in this, whether it's a transition of care or not, they should always get in the habit of reconciling the meds. It's worth 10 points but, like I said, everyone should get full credit for this category. I have down here it differs in the ACI measure set which will be for 2018 or if you so choose to report those measures this year. The difference is that they have added that it would not just

be medication reconciliation but they also want you to reconcile med allergies and also the problem list, which means that the EHR, it will have to be set up different and that's why you need 2015 Edition but you'll be comparing if any new diagnoses have been added, if the patient developed a new med allergy in the interim since they were last seen. There is that difference that you have to do three things to meet the measure in the other measure set.

Okay, and then the last performance measure is immunization registry reporting, and this is the same as it's been for Meaningful Use. A clinician can get credit for meeting this measure if they're in any type of "active engagement with a public health agency or immunization system". You don't have to be actually reporting if you're in the phase where you just completed your registration, you just contacted your Department of Health that you're ready to do it, that counts. If you're in the testing and validation phase, that counts too. This is an all or nothing kind of and if you're not, you get zero points. In the past, if you were a specialist and you didn't give them, there was an exclusion; however, there are no more exclusions, you just don't get the 10 points. But, as you'll see in a minute, CMS has cushioned this whole category so there are extra points and you really don't have to worry about losing 10 points if you don't give them. What I'm saying is, if you've never given immunizations in the past, don't feel like you have to start giving immunizations and start reporting just so you can get these 10 points.

Okay, I did just want to highlight the differences if we had gone over the ACI measure set, which like I said, it behooves you not to do that and to just wait. You do have to have 2015 Certified EHR to report them. They added another base measure. There are five base measures for this measure set, whereas, right now with the transition measures, there are only four. As you know, we currently have the summary of care health information exchange as a base measure for the transition set, which means if you're referring a patient out of your practice to another provider you send them the referral slip, tell them why you want them to be seen. What CMS did now is they created the opposite of that, so the new base measure in the other measure set is that you're requesting and accepting a summary of care document, so that would be if you are a primary care doctor, just say that you know that they went to see the cardiologist and yet he didn't send you anything, this is where you contact him and he sends you that, and then you get that in your EHR. And this is where this measure would work good for specialists because you know then they can go and retrieve that referral sheet and get credit for this category. That's something, I don't know how it's all going to be set up, but that is definitely one of the new measures for 2018 or in this other measure set.

And then the performance revisions and additions we've gone over already for patient education, the materials have to be available electronically. The reconciliation, it's now called clinical information rec, well it will be med rec, med allergies, and problem list. And then there's the request and accept a summary of care record I talked about. And then the third bullet here called patient generated health data, and this is going to be a tough one to score

points. It's incorporating data from the patient or from a non-clinical setting, such as physical therapy, or a skilled nursing home, or somewhere, into the EHR. I don't have a lot of details about this but it would give patients the ability, if they're monitoring their blood sugars at home, to go ahead and be able to upload that into their EHR electronically. I know the vendors are working on all this to make it happen, but that's one of the measures. Remember I had mentioned before, because they added more measures for this, they're all worth 10 points, so the HIE and the patient portal will no longer be worth 20 points, so it's a little bit tougher different measure set. That's why I'm not saying which one to pick but the other one is definitely more doable and I think you can get a higher score this year.

In addition to getting points for the base measures and the performance measures, there are also some bonus points available. If you report to one of the following registries you can get five bonus points: a clinical data registry, a specialized registry, the cancer registry in your state. And then I also listed syndromic surveillance and electronic case reporting. Well, a couple states have syndromic surveillance available for physicians, but I know other states only have it available for hospitals and ERs, and the same with electronic case reporting. For Meaningful Use, in the past, I know CMS really wanted everyone to report to a second registry and several practices went and joined registries and they're paying fees to report to them, professional societies or whatever, that's where you get these five extra points. It doesn't have anything to do with the immunization registry, it's over and above that, that you would get five points.

Another way to earn bonus points for this category, and it's worth 10 points, is if you use your EHR to complete one of the improvement activities that is designated as an ACI bonus activity. I'm not sure if you got to listen to Maureen give an excellent presentation about improvement activities, but there's 92 of them and 18 are eligible to award a clinician with 10 bonus points in the ACI category.

You get the credit for the improvement activity category, and then you'll also get 10 points in the ACI category to help you try to get 100 points here. If you do complete two improvement activities that have that designation for an ACI bonus it doesn't matter, you're still only going to get 10 points. You can't get more than 10 points.

Six of the activities actually relate directly to some of these measures we just went over today and just to note that all the activities are medium weight, so you would know how many points they're worth for the improvement activity category based on how many physicians are in your practice or where your practice is located.

I'm just going to briefly go over these improvement activities for having a patient portal. Here's one, it's the beneficiary engagement one, saying enhance your patient portal to provide up to date information related to chronic diseases

or blood pressure control, or include an interactive feature that allows patients to enter health information and/or bidirectional communication about med changes. It's using the patient portal and all that. Once again, and I'm not going to get into improvement activities, but you'd have to go ahead and create a procedure or policy for your practice, and document that, and have that available if you were to ever get audited. Okay, there is another one that's fits into having a patient portal and that is proactively managing chronic and preventive care. And I'm not going to read all these but basically having the patient portal, number five, you can send reminders and outreach to them about services due. If you have men that are a certain age and are due for prostate cancer screening, you could alert them it's time to have the PSA or women with mammograms. If it's flu time, I mean, anything you can think of, if you're going to use the portal you really do qualify for meeting this measure.

Okay, for patient education we saw how everything's going to have to be done electronically anyway, so there is an improvement activity that talks about using the portal to go ahead and have that education available. For the health information exchange, there are two activities out there that talk about bilateral exchange of information. Using the HIE in your state or it can be direct messaging and it's getting those specialist reports back and forth to each other. There's some in the care coordination category. And then, we talked about medication reconciliation is still a measure and there's a couple activities for that. This one in population management talks about managing meds to maximize efficiency, effectiveness, and safety. And then med rec is one of the first things you can do. And when they list multiple different activities, just know that you don't have to do all of them, just select one of them. And the other med rec activity, we've already seen on another screen, and if you look at number six, it specifically says, "Perform routine medication reconciliation." If you are doing medication reconciliation, and hopefully you are, and hopefully you have a great measure rate, this also would qualify as one of your improvement activities.

All right, so let's talk about how is the Advancing Care Information category scored? We talked about having to have a base score, 50 points. If you don't get those 50 points you get zero points for this category all together. Then we talked about the performance measures, there were seven of them. Six of them had numerators, denominators, the other one was the immunization. They're all worth 90 points. And then we talked about the possibility of bonus points. As you can see there's 155 possible points and CMS gave this 55 extra point cushion because they don't want clinicians to feel that they have to focus on certain measures that really are not applicable in their practice but that they still deserve to get credit for this category.

Anyone that scores 100 or more points, you're going to get full credit for this category and I can confidently say that if you met Meaningful Use in the past you should definitely be able to get full credit for this category, which means that's 25 points already towards your MIPS score, which means that it's already a small positive payment adjustment, so that is really good. And then, when you

put that hand-in-hand with doing some of those improvement activities you've got your 15 points from there, so already we're talking that you should all have 40 MIPS points as of right now without even looking at your quality measures. When you get your Advancing Care Information score we need to convert them to MIPS points because each little category is measured and scored differently.

What you're going to do, and I'm going to give some examples, is actually look at what Advancing Care Information score you get by adding those three different measure scores and multiplying by .25. And the reason for that is because the whole category is worth 25% of your MIPS score. As I said, the maximum points you can get for this category is 25 points. No one can get 26, you can't get extra, just 25. In the little table here if you get 100 points for your ACI score, you multiply that by .25, you get 25 MIPS points, that's the max. Someone that gets 83 points for their ACI score, multiply that by .25, they're going to get 20.75 out of 25 points, which is still really good.

If someone does exceptionally well and they get 134 points when they add all their measures up, you multiply it, guess what? They still only get 25 MIPS points. Once again, CMS just built that cushion in there so that you don't have to worry about, "Oh, my gosh. How am I going to send 100 summary of care documents?" When really why do that in your practice if it really isn't applicable. Let's concentrate on measures that are more applicable. Here, I know this is kind of small, but this is going to give you some examples. These are actually measure rates from practices I've been working with. I've been looking at either their 2016 Meaningful Use data or now that the quarter is almost over, looking at the 2017 Meaningful Use Dashboard. They give me the measure rates and we can plug them into here.

Security risk analysis, we're going to say, "Yes, you're definitely going to have that done by the end of this year." E Prescribing, let's enter your numerator and denominator. Provide patient access, how many people are enrolled with your portal? This practice did excellent. All but one patient is signed up to use their portal, and then summary of care, this practice did really well, and they, out of 103 transitions they did do it 14 times which is really high. When you add all those up you get, in this last column, your ACI points, which are 50. Now we go down to those performance measures where the maximum number of points you can get is 90 because the first two are worth 20 and the others are worth 10.

This one, in order to calculate, you really need your measure rates, we don't need the exact numerator and denominator, so this provider, like I said, had almost everybody enrolled with the portal. Their HIE measure rate was actually pretty good at 13%. View, download, transmit, 30%, which is still pretty good that, that many patients were active with it. Patient education surprised me, 22%, because a lot of providers are used to giving out some type of educational material during an office visit. Secure messaging, sending patients messages back and forth, was only at 10%, okay. Med rec, this practice had been doing it

on everybody, all the time so they were at 100%. And this practice did do immunization reporting.

Then, when we go back and we convert this to points, and I had a table in a earlier slide, you can see the points, okay. For the secure messaging, they only got one point for that. Patient education, they didn't do really well, they only got three points out of 10. But here's what I want to show you, when you still add all these up, you're still at 101 points and they get full credit. And just to note, on the bonus category they did not report to another registry and at this time we said no, that they did not do an improvement activity but everybody should probably pick at least one activity to get those 10 points, one of those that we went over, such as med rec. If they did then they would have 111 points.

I want to just show you that this practice or this clinician is getting full credit for that even though he didn't do really well on these measures. Now, if he was borderline and that close would I tell him to concentrate on summary of care as well? "Let's pick a measure where I know you can do better on, let's do the secure messaging, send a mass message out, or let's try to improve on the patient education, getting more of that educational materials out and getting credit for that."

Okay, here's another example, so this clinician did not get full credit, he didn't get 100 full points. He still got 23 MIPS points and you can just look, we plugged in the numerator and denominator, he did summary of care two times for 30 transitions and you can see the other measure rates, nothing phenomenal but he's at 92. For this one I would definitely tell this practice, "Let's do one of the improvement activities using CEHRT," that would get them 10 points, they'd be at 102 and they'd get full credit, which means that all these other measure rates, even though they're low, you don't necessarily have to focus on improving them. Would it behoove them to do that? Yes. I'd say try to do med rec on everybody, try to get more people enrolled with the portal but if you're a practice where you're trying and not enough people are signing up, that's okay. Let's pick one of the other measures where we can try to get some more points to get you over that 100.

And then, I do have an example of someone that was unable to do any summary of care document exchanges. One transition of care is identified, and none sent, which means that if we were doing a MIPS score based on this practice they would have zero points, no ifs, ands, or buts. Even though when we plug in their rates for everything else, look at this, they had 100% of their patients enrolled with the portal, they get 20 points there. Med rec, they were at 90%, so they're still getting 49 out of 90 points but guess what? Those 49 points don't matter because they didn't meet the base measures, so that's why you have to do that summary of care for at least one patient.

That's where you look, you see where you are, and then focus efforts on getting at least one summary of care done, and then if you're over the 100 then you're

good to go, and then let's go focus on the Quality category because I think everyone needs to improve over in that category because if this clinician, as I've noted up here, had just sent one summary of care, he'd have 109 total points so he'd get full credit for ACI. That's why I just basically want to say again, if you've done Meaningful Use in the past that you really should be able to get full credit for this category.

Submission methods, if you report these measures on an individual clinician level, it can be done via attestation. CMS is going to be building a platform probably very similar to the registration and attestation system we use currently for Meaningful Use, and then you can also have a vendor do it through your EHR or you can go through a registry and submit it. Group reporting, you have those three options or if you have 25 or more clinicians, you can use the CMS web interface, and remember the submission methods can vary between the different categories. One thing I did want to talk about, group reporting for this category, remember what you're going to do then is add all of the data for all the clinicians that report on that measure, okay, and that is the number, one numerator and denominator will be submitted to CMS, so it's a combination of everybody in the TIN, okay.

If you have several low performers and one high performer it's going to really bring the high performer down but the low performers up a little bit, so that's where you'll need to figure out, and this is across all the categories, which way do we really want to do it? Hospital based clinicians and then those optional ACI reporting clinicians, once again, they don't have to report ACI this year but if they submit any data, their ACI is attached to any of those measures, it will be scored and then it would not get re-weighted to quality and I already think I told you if you're in an ACO you have to do it as a group.

And this is just a basic table to show you what you do, the way you perform this year is going to affect your payments in 2019, so we definitely don't want anyone to have zero points. We want everyone to submit at least one measure, preferably I would say try to submit all measures in all categories and see what your score is like. A lot of you, CMS is expecting a lot of people to be in this four to 69 point category, which right now they're saying you can get an adjustment up to 4%. If you get over 70 points you are also eligible for that exceptional performance bonus where you can get a minimum of an additional .5%.

As I said, if you get full credit for the Advancing Care Information and improvement activity categories, that's 40 points already, which means you need 30 out of your 60 points for quality to put you at that 70 point range, so we really hope that you can reach out to us and we can try to help you get there. One of the things we are working on is getting a MIPS calculator branded that we can show you and put on our website that will be really easy to use where you're just entering numerators and denominators and the algorithms are built in, and then all of a sudden, your MIPS score appears as you enter the data. Whether you want to do it on a monthly basis, quarterly, or whatever, you can track where you are with your MIPS score. There's an Advancing Care

Information tab, a Quality tab, and then you can also see your total MIPS score with the improvement activities added.

One thing, and I see I'm just about running out of time and I apologize, is that CMS just announced yesterday that they are having a webinar next week, on Tuesday, where they're going to give a deep dive into the same category I just went over. I hope that all of our information agrees with each other. I do use the Quality Payment Program website all the time to get our information and there is a registration link and we will be sending a newsletter out to remind you about that also. This slide is just a list of contacts in all of our states.

If you are currently working with us, reach out to us with questions. If you are not yet, please reach out to us and we would love to help you. And there's the link for our Quality Insights website, and also the Quality Payment Program website, which like I said, is the most valuable thing, that's the Bible for the whole program. And I see that it is 1:58 and I apologize so much for talking so much. I am just scrolling down and I see that we've got a couple things in the chat and let's see where we are with questions. Okay, there's a couple questions in there and what I'd like to do because I see some of them are answered but what I'd like to do is just in respect of everyone's time is go ahead and I apologize that we can't answer these verbally but we'll leave it open for another minute so please submit your written questions and then we will go ahead and type all of them up and send them out to everybody that has registered or attended.

Thank you so much for listening to me talk on for an hour. I hope you've learned something and I hope you get all the credit you can for the Advancing Care Information. Thank you.

Laurie Fink: Thanks, Kathy, and I just want to remind everyone when you close out of today's session there is very, very brief evaluation, just six questions long. If you could please complete that for us, it helps us gauge what you gathered from this session and how we can better help you moving forward, so thanks again for joining us today. Have a great rest of day and this now concludes the session. Thanks.

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