MIPS Advancing Care Information: Tips, Tools and Support

Q&A from Live Webinar – March 29, 2017

Below are questions that were submitted during the Quality Insights Advancing Care Information webinar on March 29, 2017.

The Centers for Medicare and Medicaid Services (CMS) held a webinar on April 4, 2017 entitled, "ACI Deep Dive." During the webinar, CMS acknowledged that they forgot to take special circumstances into consideration for the health information exchange (HIE) base measure and they plan to add an exclusion for certain clinicians for the HIE measure. Answers highlighted in red in the following Q&As reflect the new information from CMS. Quality Insights will notify everyone as soon as CMS changes the specification sheet for the HIE measure.

Reporting Questions:

1. **Can a practice of two providers report as a group?**
   Answer: Yes, two clinicians are considered to be a group.

2. **Back to the group reporting, if we have 20 ECs and are reporting by group, do we need "at least one" in every category or "at least one" for each provider?**
   Answer: If you submit ACI measures as a group, then you only need one in the numerator for each of the three base measures that requires a numerator and denominator (eRx, Provide Patient Access, and HIE). Each provider in the group does not need to have one.

3. **Does a nurse practitioner (NP) count as a group participant?**
   Answer: A NP will count as a group participant if the NP bills Medicare Part B using his/her individual NPI. If the NP bills under a physician or group NPI, then the NP does NOT count as a group participant.

4. **When we attest for ACI as a group, will it be the average of all individual providers?**
   Answer: YES, if you submit ACI measures as a group, the numerators and denominators will reflect an aggregate of everyone's data. This is calculated by adding everyone's numerators and denominators then dividing them by the total number of clinicians in the group.

5. **Is it straight Medicare or does that include Medicare Advantage plans?**
   Answer: Medicare Advantage plans are not included in MIPS.

6. **My NP and PA bill under our group NPI, not individually. When I submit the data next year I will be using all the data from all providers. Will they still be counted and my numbers won't be redistributed?**
   Answer: If you report ACI measures at the individual clinician level, the NP and PA will not have data because they both bill under your group NPI. However, if you report ACI measures as a group, data from the services they provide will be included because CMS will be reviewing data at the TIN level. The ACI score will represent everyone in the group and the final MIPS score of the group will be applied to all of the providers that bill under the TIN.

7. **I am a billing service, do I report these measures or are these coming straight from the EHR?**
   Answer: Advancing Care Information measures can be submitted to CMS via registry, EHR, or attestation, but not via claims. Only quality measures can be submitted via claims.

8. **For advancing care information, if paper practices go onto a 2015 EHR at any time in 2017 and have one patient for each of these measures, will they get full credit for ACI?**
   *Answer: No, you can only earn **half** credit by having a one in the numerator to meet the four ACI Transitional BASE measures. The Privacy & Security Analysis will also need to be completed during CY 2017. If you want to earn **full** credit for the ACI category, you must earn an additional 50 points. This can be earned by adding points from performance measures or bonus points. You must earn a minimum of 100 ACI points to receive full credit (25 MIPS points). Meeting only the BASE measures will award 12.5 MIPS points.*

9. **We are changing our EHR in November of 2017. Can we use the first 10 months for MIPS only?**
   Answer: 2017 is the transitional year for the Quality Payment Program and CMS is providing numerous options so clinicians can 'pick their pace' of participation. Clinicians can select any dates and time period that they want to report ACI measures; however, the more measures you report and the longer the period of time, the greater the possibility of earning more ACI points. So, yes, you can use the first 10 months to report measures for MIPS if you want to.

10. **Do we have to register with Medicare to sign up for MIPS or do we just report?**
    *Answer: Registration is only required in two circumstances and the registration deadline is June 30, 2017. Registration is required for practices that are going to do group reporting and submit measures using the **CMS Web Interface** OR submit the **CAHPS Survey** as a quality measure. Otherwise, no registration is required and nothing needs to be submitted to CMS until the first quarter of 2018 when the MIPS submission deadline for 2017 is 3/31/18.*

11. Some of my docs don't use EHRs. If I bill the codes will they still get credits?

Answer: Clinicians that do not have an EHR cannot earn any points for the ACI category. However, quality measures can be submitted using claims so the clinicians can earn MIPS points for the quality category or the improvement activity category.

12. Please review what information we should use to decide whether to report individually or as a group.

Answer: Whether to report as a group or individually is a business decision and there are advantages and disadvantages to both. If you review your previous year's QRUR report, PQRS data, and Meaningful Use report, you will have an idea if the clinicians in your practice are high, medium, or low performers. You should also consider what resources are available in your office to monitor clinicians' performance on a routine basis so you can implement workflow changes to improve measure rates.

Eligibility Questions:

13. Is the 100 patients/year cumulative for all practitioners in a group practice or must EACH provider bill a minimum of 100 patients?

*Answer: The 100 patients are assessed under the TIN if the practice is going to do group reporting. The 100 patients are assessed under the individual clinician NPI if the practice is going to do individual reporting. MIPS eligibility is determined at the individual clinician level if individual reporting is selected. In order to participate in MIPS, a clinician must bill Medicare Part B ≥ $30,000 per year **AND** see >100 Medicare patients per year. If the individual does not meet both of these requirements they are not eligible to participate. If a practice decides to report as a group, then the eligibility status is determined at the group level. Claims data from the TIN will be reviewed to see if there were ≥ $30,000 Medicare Part B allowed charges **AND** >100 Medicare patients were seen. If both of these thresholds are met, then the group is MIPS eligible. Therefore, it is possible that clinicians in a practice who would be exempt from MIPS due to a low patient volume as an individual, must participate in MIPS when they are part of a practice that is going to do group reporting.*

14. We are pediatrics, seeing less than 10 Medicare patients. Are we exempt from MIPS?

*Answer: MIPS eligibility is determined at the individual clinician level if individual reporting is selected. If a pediatrician does not bill Medicare Part B ≥ $30,000 per year **OR** see >100 Medicare patients per year, the pediatrician is exempt from MIPS. However, if the pediatrician belongs to a practice that decides to report as a group, then the MIPS eligibility status is determined at the group level. Claims data from the TIN will be reviewed to see if there were ≥ $30,000 Medicare Part B allowed charges **AND** >100 Medicare patients were seen. If both of these thresholds are not met, then the group is not MIPS eligible and will not receive a negative 4% penalty from Medicare in 2019.*

15. **All providers in our organization (FQHC) are participating in the Medicaid EHR Incentive Payment Program. Do we also have to participate in MIPS?**
*Answer: FQHCs are not paid on the Physician Fee Schedule, so clinicians working in FQHCs are not required to participate in MIPS **unless** a clinician bills Medicare Part B for items and services, such as those under the Physician Fee Schedule. Currently, clinicians working in FQHCs can participate in their state Medicaid EHR Incentive program if they meet the Medicaid patient volume threshold. For the past few years, clinicians who attested to Meaningful Use through their state Medicaid program were required to also attest with Medicare if the clinician billed Medicare Part B services or the clinician would receive a Medicare penalty. This same rule will apply with MIPS. If a clinician bills Medicare Part B for items and services, such as those under the Physician Fee Schedule, the clinician will need to participate in MIPS or a MIPS Medicare penalty will be applied to the Medicare Part B claims. Services rendered by a clinician that are payable under the FQHC methodology are not subject to the MIPS payment adjustment.*

16. **If we are not required to participate as an FQHC, should we start this process to prepare for 2021 when the Medicaid EHR Incentive program ends?**
Answer: FQHCs are not paid on the Physician Fee Schedule, so clinicians working in FQHCs are not required to participate in MIPS UNLESS a clinician bills Medicare Part B for items and services, such as those under the Physician Fee Schedule. Currently, clinicians working in FQHCs can participate in their state Medicaid EHR Incentive program if they meet the Medicaid patient volume threshold. For the past few years, clinicians who attested to Meaningful Use through their state Medicaid program were required to also attest with Medicare if the clinician billed Medicare Part B services or the clinician would receive a Medicare penalty. This same rule will apply with MIPS. If a clinician bills Medicare Part B for items and services, such as those under the Physician Fee Schedule, the clinician will need to participate in MIPS or a MIPS Medicare penalty will be applied to the Medicare Part B claims. Services rendered by a clinician that are payable under the FQHC methodology are not subject to the MIPS payment adjustment.

Hardship Questions:

17. **Under the EHR Incentive Program, EPs could only claim a hardship exemption for five years. Any idea if MIPS will have any such limitation to how many times an EC can claim hardship for ACI?**
Answer: Medicare clinicians could only participate in the Medicare EHR Incentive program for 5 consecutive years, so that is probably why the hardship was only available for five years. The current Final Rule does not address this question. Every year, CMS is required to publish regulations for the following year. We know that hardship exception applications will be available for the 2017 reporting year sometime this summer, but we do not know about future years.

18. **Where do we find the hardship application?**
    Answer: Hardship applications for EPs that did not meet Meaningful Use in 2016 are currently available (called the 2018 Hardship Application) and must be submitted by 7/1/17. Hardship applications for the ACI category for 2017 will be available on the QPP website this summer. The 2018 Hardship Application can be found here.

19. **We are in the process of procuring a Certified EHR and the implementation process has not yet begun. It is expected to be fully implemented in 8 months. Will this give us time to report on ACI measures or should we apply for hardship?**
    Answer: If you implement a certified EHR, including a patient portal, prior to the end of the year, you can probably earn at least partial credit for the ACI category, but you must meet the 4 base measures. You do not need to make a decision about applying for a hardship exception until the year ends. Remember that CMS reviews each hardship application individually to determine if one of the qualifying criteria to be approved is met.

Base Measure Questions:

20. **Where can we find a list of base and performance measures for 2018?**
    Answer: 2018 measures will be finalized later this year during the 2017 rule making process. The current Final Rule states that everyone will need to report the ACI measures in 2018 because the ACI Transitional measures were only created for this transitional year. A list of the ACI base and performance measures is located on the QPP website. Please see the document called "Advancing Care Information Measure Specifications" which was posted on 3/13/17. Select the file for MIPS ACI Measures.

21. **If they have already conducted a Security Risk Analysis, can they use that one for 2017 as long as they review it and update it?**
    Answer: The Privacy & Security Risk Analysis must be updated annually. If you completed a P&S analysis for CY 2016 to meet Meaningful Use, you can review it, update it, and address deficiencies for calendar year 2017.

22. **Do they have to use the portal or just be provided access?**
    *Answer: One ACI measure (**Provide Patient Access**) requires the patient to enroll with the portal and have information updated within 4 business days. Another ACI measure (**View/ Download/ Transmit**) requires the patient to use the portal. The **Provide Patient Access** measure is both a base measure and a performance measure. Therefore, at least one patient must be enrolled with the portal if the clinician wants to earn any ACI points.The **View/ Download/Transmit** measure is only a performance measure, so it is acceptable if no patients actually use the portal. If they don't, the clinician would not receive any points for the **View/ Download/Transmit** measure.*

23. **When reporting as a group, is the numerator "1" for EACH provider or for the group?**
Answer: When reporting as a group, aggregated data is submitted at the TIN level. Therefore, only "1" is required in the numerator for the base measures. Each clinician does not need to have a "1." Therefore, one prescription has to be e- prescribed, one summary of care document has to be sent electronically, and one patient must be enrolled with the portal. It doesn't matter if the "1" in the numerator came from one clinician or more than one clinician-everyone in the group gets credit for meeting the base measures with just "1."

24. **As far as the base score goes, only patient per category is needed to achieve a "pass" score in each category (except of course E-Rx since there is an exclusion), correct?**
Answer: YES – in order to receive 50 ACI points for the base measures, you must have a numerator of at least "1" for each Base measure plus answer "YES" for having the Privacy & Security Risk Analysis. There is currently an exclusion for the e-prescribe measure for clinicians who write fewer than 100 prescriptions during the reporting period. However, on 4/4/17, CMS acknowledged during the ACI Deep Dive webinar that CMS is working on a solution so certain clinicians can be excluded from the HIE measure too.

25. **In regards to providing patient access, can we still count patients who say they do not have an email address and we give them info about creating an email about our portal? Also, can we count the patients that portal invites were sent to but not accepted?**
Answer: Please check with your vendor to see how you get credit for the Provide Patient Access measure because vendors set up their systems differently. The clinician should not be penalized if a patient is asked to enroll, but refuses.

HIE Questions:

26. **When it says at least one patient/transition, if you are submitting as a group, is that one per provider in the group or one for the entire group?**
Answer: If your practice does group reporting, then only one Summary of Care record needs to be sent electronically for a transition of care during the reporting period. Therefore, only one clinician has to do this this and everyone else in the group gets credit for it.

27. **Can you please repeat what you said about providers being all under the same TIN and health info exchange between these providers?**
Answer: A clinician will NOT get credit for the HIE measure for electronically sending a summary of care record to another clinician that is under the same TIN and uses the same EHR. However, on 4/4/17, CMS acknowledged during the ACI Deep Dive webinar that clinicians who refer patients to specialists in their health network who share the same TIN would be unable to meet this measure; therefore, CMS is working on a solution so certain clinicians can be excluded from the HIE measure.

28. **On Health Information Exchange, explain "where providers do not share same EHR". Meaning the same database or has to be 2 different EHR's (EPIC to ECW but not ECW to ECW in different offices). For example we use ECW but send to other ECW specialists.**
Answer: Currently, the Final Rule states that a transition of care for HIE occurs when the referring provider is under a different billing identity (TIN or CCN) than the receiving provider AND the providers do not share access to the same EHR. The "same EHR" would be the same database. Clinicians can get credit for sending a summary of care record to another clinician that uses the same EHR vendor (example: Primary Care uses eCW and specialist uses eCW) BUT the 2 clinicians must be under different TINs. However, on 4/4/17, CMS acknowledged during the ACI Deep Dive webinar that CMS is working on a solution so certain clinicians can be excluded from the HIE measure.

29. **If I have 80 providers under one TIN and am group reporting, does only one provider have to meet the HIE to get credit for the whole group?**
Answer: Yes, only one clinician has to send a summary of care record and the group will get credit for meeting this base measure. However, remember that HIE is also a performance measure, so summary of care records should be exchanged for all transitions of care if the group wants to earn maximum points for the HIE performance measure.

30. **If reporting on the group level, is it still one patient per group?**
Answer: If you are referring to the HIE measure, then the answer is yes. For group reporting, only one clinician needs to send one summary of care record electronically to a clinician in another TIN to meet the base measure.

31. **We are an Urgent Care who does not exchange summary of care to a receiving healthcare clinician regularly, only upon request. This can be a lot of points lost for performance, so can this make one exempt from MIPS? It would have negative impact on our score.**
Answer: According to the current Final Rule, at least one summary of care record must be sent electronically for a transition of care during the reporting period. If this is not done, the clinician/group would not meet all of the Base measures and would therefore not receive any points for the ACI score. The maximum possible MIPS score would be reduced to 75 points because the clinician/group could not earn any of the 25 MIPS points for the ACI category. However, on 4/4/17, CMS acknowledged during the ACI Deep Dive webinar that CMS is working on a solution so certain clinicians can be excluded from the HIE measure.

32. **We are a Physical Medicine & Rehab practice with two chiropractors under the same TIN as the physicians. They do not transition patients to outside physicians for care. How would they meet the base measure of HIE?**
Answer: There are two things to consider based on whether your practice plans to report MIPS data individually or as a group. If all of the clinicians (rehab physicians and chiropractors) want to report measures individually, then each clinician will need to send at least one summary of care record electronically during the reporting period if he/she wants to earn ACI points. Since the chiropractors do not routinely transition patients, they could

consider sending a summary of care record to one of their patient's primary care providers to meet the measure. Another possibility for the chiropractors is to send the summary of care record electronically to another clinician when a patient moves or leaves the practice or needs follow-up with an orthopedic surgeon or neurologist. On 4/4/17, CMS acknowledged during the ACI Deep Dive webinar that CMS is working on a solution so certain clinicians can be excluded from the HIE measure.

Performance Measure Questions:

33. When do you have to post patient education on the portal?

Answer: Patient Education is a 'performance' measure which means that the measure does not have to be reported unless the clinician or group wants to try to obtain 1-10 points towards their ACI score. If a clinician reports the ACI Transitional measures this year, educational materials do not need to be provided electronically to the patient, but if the ACI measures are reported, then educational materials do need to be provided electronically.

34. For secure messaging, does it have to be the provider sending the message, or can it be another user, such as office manager, nurse, MA, etc.?

Answer: Please check with your EHR vendor to see how you get credit for meeting this measure. Most EHRs require the physician to send the message.

35. Does that mean that if we have a group of 10, then we need 10 patients doing secure messaging or still just 1 for the group?

Answer: Secure messaging is not a base measure. It is a 'performance' measure which means that the measure does not need to be reported unless the clinician or group wants to try to obtain 1-10 points by reporting this measure. The higher the performance rate, the more ACI points are awarded. If only 1 is in the numerator, it is likely that zero or 1 point will be awarded. Because you are going to report as a group, the denominator for this measure is ALL of the unique patients seen during the reporting period by ALL 10 clinicians. The numerator is the number of ALL unique patients seen during the reporting period by ALL 10 clinicians who sent a secure message to the clinician or received a secure message from a clinician.

36. For provide patient access, is it how many patients have registered for the portal or how many patients have their information (CCDA) available for review? We send a CCDA to each patient after being seen.

Answer: The numerator for the Provide Patient Access measure represents the number of patients in the denominator who are provided timely access to health information to view online, download, and transmit to a third party. This means that everyone who is enrolled with the portal must have their CCDA available within 4 days of an office visit or when test results become available to a clinician. A simple answer to your question is that the numerator reflects how many patients have registered for the portal.

ACO Questions:

37. I just wanted to clarify that for providers that are in a MSSP 1, the quality measure that will be used for these providers is what the MSSP reports. The MSSP quality trumps the individual/group quality, correct?

Answer: Correct. The MSSP 1 ACO is responsible for reporting quality measures to CMS on behalf of all practices in the ACO.

38. Since we are in an MSSP ACO and quality is from the ACO, we must focus on those quality measures, correct?

Answer: Correct. The ACO selects and reports quality measures for all practices in the ACO.

39. As part of an ACO, our MIPS score for quality and improvement activity categories will be based on the ACO. Will we have to report a full year for ACI since the ACO's date encompasses a full reporting year?

Answer: Under MIPS, each category reporting period is independent, so the ACI category can have a different time period than the quality or Improvement Activity category. Since you are part of an ACO, your practice may be reporting under the APM model rather than MIPS. Most ACOs request that each TIN submit their ACI measures directly to CMS, even though the ACO will still receive one ACI score based on rates from all of the TINs. It is recommended that you contact your ACO to see if they want you to report ACI measures for a specific time frame.

40. To clarify, as long as you do something, there will be no negative adjustment, even if the ACO quality measures are not higher than other groups/providers.

Answer: Correct. If you belong to an ACO, the ACO will report quality measures as a group. Additionally, everyone in the ACO receives full credit for the Improvement Activity category. Therefore, no one in the ACO will have a negative payment adjustment.

41. If our pediatricians are in an ACO but do not see over 100 patients or bill over $30K, are they still included in MIPS? Since we have to report at the group level, I get the impression they are included. Is that correct?

Answer: Yes. When group reporting is done, MIPS eligibility is determined at the group level and not the individual clinician level. Therefore, it is highly unlikely that all of the NPIs associated with the ACO TIN will bill < $30,000 to Medicare Part B and see < 100 Medicare patients. Therefore you are correct that the pediatricians in the ACO must participate in MIPS even though they see fewer than 100 Medicare patients individually.

42. Is the pediatric exclusion (10 Medicare patients) regardless of whether they are in an ACO? They would still be exempt?

Answer: Pediatricians who see less than 100 Medicare patients annually are exempt from MIPS; however, if the pediatric practice belongs to an ACO, group reporting must be done so it doesn't matter if some of the clinicians in the ACO are not MIPS eligible clinicians. Data

from all clinicians is reported at the group level and the ACO will receive one MIPS score for everyone.

43. ACO reporting as group - is it true that only 1 of my 100 physicians need to meet the Base score?

Answer: ACOs report as a group; therefore, only a one is needed in the numerator for the three base measures that require a numerator and denominator, i.e. only one patient needs to be enrolled with the patient portal, only one summary of care record needs to be sent electronically to a clinician in another TIN, and only one patient has to have a prescription electronically prescribed. The Privacy & Security Analysis will also need to be completed during CY 2017 so all four ACI Transitional base measures are met. It doesn't matter if one of your 100 clinicians meets all of the base measures or 2, 3, or 4 different clinicians meet the different measures because everyone in the practice gets credit. Remember that two of the base measures are also performance measures, so it is to your advantage to have as many clinicians meet the Provide Patient Access and HIE measures.

44. Will we get an email with the MIPS Calculator tool when available?

Answer: Yes. We will notify everyone in a MACRA/MIPS e-newsletter when the MIPS Calculator is available.

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