Maximizing MACRA / MIPS Scores Through Care Management Services

See which MIPS categories & measures
can achieve high performance scores through:

Chronic Care Management

Preventative Care Management

Virtual Care Management

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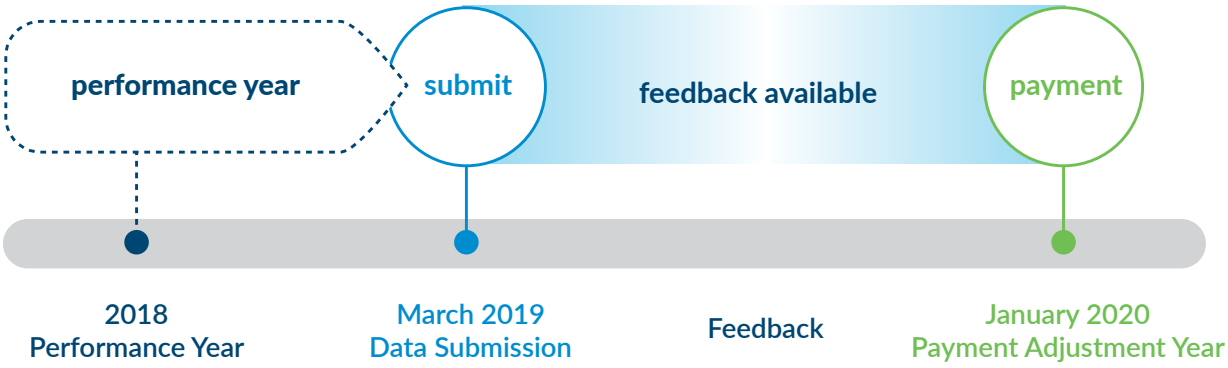
MACRA/MIPS Incentives

In 2015, the Centers for Medicare & Medicaid Services (CMS) began to incentivize practices to move from a fee-for-service model to value-based care. The Medicare Access and CHIP Reauthorization Act, better known as MACRA, is legislation that restructures how physicians are paid by Medicare with a focus on outcomes and quality of care improvement.

MACRA requires an implementation of the Quality Payment Program with two ways for eligible clinicians to participate: Advanced Alternative Payment Models (Advanced APMs) and the Merit-based Incentive Payment System (MIPS). Under MIPS, **CMS will apply a payment adjustment to each MIPS eligible clinician based on a final performance score across four performance categories.**

MIPS Performance Categories for the 2018 Performance Year

Each MIPS Performance Year begins on January 1 and ends on December 31 of that year. Program participants must report data collected during that calendar year by March 31 of the following calendar year.



In the 2018 MIPS Performance Year, performance is measured through the data clinicians report in four areas: Quality, Improvement Activities, Promoting Interoperability (formerly Advancing Care Information), and Cost.[1]

Who Can Participate in 2018?

In the 2018 performance year, the following clinician types can participate in MIPS:

- Physicians, which includes doctors of medicine, doctors of osteopathy (including osteopathic practitioners), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Any clinician group that includes one of the professionals listed above.

The Quality category covers the quality of the care you deliver, based on performance measures created by CMS, medical professional and stakeholder groups. You pick the six measures of performance that best fit your practice.

Formerly Advancing Care Information, the Promoting Interoperability category was recently renamed to focus on patient engagement and the electronic exchange of health information using certified electronic health record technology (CEHRT). This is done by proactively sharing information with other clinicians or the patient in a comprehensive manner.

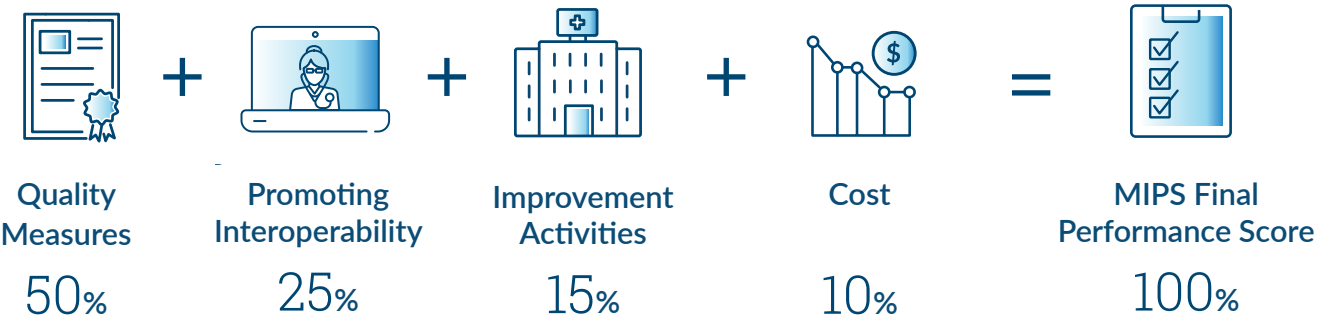
The Improvement Activities category includes an inventory of activities that assess how you improve your care processes, enhance patient engagement in care, and increase access to care. The inventory allows you to choose activities from categories such as, enhancing care coordination, patient and clinician shared decision-making, and expansion of practice access.

Cost is a new performance category in 2018 that calculates the cost of care you provide based on your Medicare claims. MIPS uses cost measures to gauge the total cost of care during the year or during a hospital stay.

The 2018 Performance Year Categories are Quality, Promoting Interoperability, Improvement Activities & Cost.

MIPS Final Composite Score Calculation

The four performance categories are each weighted differently and scored separately as a portion of a final composite performance score:

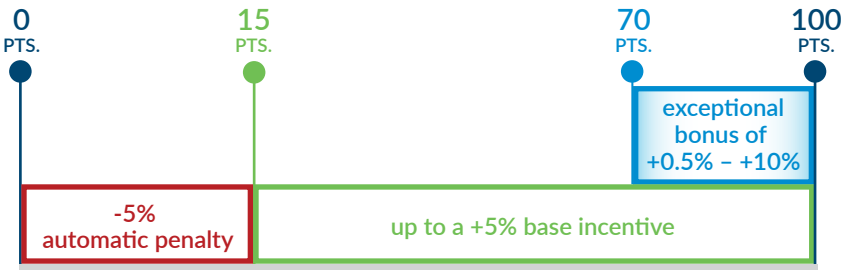


Performance Thresholds for the 2018 Performance Year

There are two MIPS performance thresholds: 1) the performance threshold and 2) the additional performance threshold for exceptional performance. The performance threshold for the 2018 performance year/2020 payment year is 15 points (increased from 3 points in the previous year.) In other words, MIPS eligible clinicians need a 2018 MIPS final score of at least 15 points to avoid a negative payment adjustment in 2020.

Doctors will need to score 15 points in 2018 to avoid penalty. If this performance threshold is not reached, clinicians will receive and automatic -5% reduction from their 2020 payments.

The additional performance threshold for exceptional performance for the 2020 MIPS payment year is 70 points. A MIPS eligible clinician with a final score of 70 points or higher will receive an additional payment adjustment factor for exceptional performance.



Payment Adjustments for the 2020 Payment Year

0-14 points

If you do not reach the 15-point performance threshold in 2018, you will automatically have -5% reduced from your 2020 Medicare fee schedule.

15-100 points

CMS will take the funds of those who did not meet the performance threshold and distribute them among those who did so that the latter will receive a portion of up to a +5% increase to their 2020 Medicare fee schedule.

70 points

A MIPS final score of at least 70 points passes the exceptional performance threshold and qualifies for the Exceptional Performance bonus money. CMS has set aside an additional $500 million for these additional positive adjustments and will be based on a linear sliding scale range of +0.5% up to +10%.

Looking Ahead to the Future of MIPS

In performance year 2019, **the proposed performance threshold is a score of at least 30 points to avoid penalty.**[2] **Payment adjustment factors will also increase** by 2 percentage points each performance year to -7/+7% in 2019 and -9/+9% in 2020.[3]

Despite frequent changes to requirements and incentives, MIPS has a continued trend of increasing impact to the financial outcomes of a practice. More eligible clinicians are finding it necessary to implement measures without impeding on their current workflow or practice capacity. **Outsourcing Chronic Care Management, Preventative Care Management, and Virtual Care Management services help ensure compliance, provide better clinical care, and maximize MIPS performance scores now and into the future.**

Despite frequent changes, MIPS has a continued trend of increasing impact to the financial outcomes of a practice.

Sources:

1. MIPS Overview: https://qpp.cms.gov/mips/overview
2. Proposed Rule for the Quality Payment Program Year 3, page 4: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-QPP-proposed-rule-fact-sheet.pdf
3. MIPS Incentive Payment Formula, chart on slide 17: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf

Chronic Care Management

Preventative Care Management

Virtual Care Management

Maximize MIPS Scores Through **Chronic Care Management**

Chronic Care Management (CCM) is the coordinated care of patients living with multiple long-term chronic conditions. The Wellbox CCM program is tied to MIPS performance categories in order to **help physicians and practices achieve high-performance scores.**

Quality Measures
(most heavily-weighted category)

The Wellbox CCM program can help meet 60 measures, including 25 high-priority measures (*), in all six of the Quality Measure domains

Effective Clinical Care (32 Measures)

- Adult Kidney Disease: Blood Pressure Management*
- Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis*
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
- Anti-Depressant Medication Management
- Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy
- Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
- Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy
- Breast Cancer Screening
- Cervical Cancer Screening
- Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy
- Colorectal Cancer Screening
- Controlling High Blood Pressure*
- Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy
- Coronary Artery Disease (CAD): Antiplatelet Therapy
- Coronary Artery Disease (CAD): Beta-Blocker Therapy
- Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management
- Dementia: Functional Status Assessment
- Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy Neurological Evaluation
- Diabetes: Eye Exam
- Diabetes: Foot Exam
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)*
- Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy
- Heart Failure (HF): Beta-Blocker Therapy
- HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis
- Hypertension: Improvement in Blood Pressure*
- Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury Bone Loss Assessment
- Optimal Asthma Control*
- Parkinsons Disease: Psychiatric Symptoms Assessment
- Rheumatoid Arthritis (RA): Glucocorticoid Management
- Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
- Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Patient Safety (6 Measures)

- Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days
- Dementia: Safety Concerns Screening and Mitigation Recommendations or Referral for Patients with Dementia*
- Documentation of Current Medications in the Medical Record*
- Falls: Risk Assessment*
- Falls: Screening for Future Fall Risk*
- Use of High-Risk Medications in the Elderly*

Person & Caregiver-Centered Experience & Outcomes (8 Measures)

- Adult Kidney Disease: Referral to Hospice*
- Average Change in Back Pain following Lumbar Discectomy / Laminotomy*
- Average Change in Back Pain following Lumbar Fusion*
- Average Change in Leg Pain following Lumbar Discectomy and/or Laminotomy*
- CAHPS for MIPs Clinician/Group Survey*
- Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options*
- Oncology: Medical and Radiation Plan of Care for Pain*
- Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65+*

Efficiency & Cost Reduction (2 Measures)

- Age Appropriate Screening Colonoscopy
- Medication Management for People with Asthma*

Community/Population Health (7 Measures)

- Pneumococcal Vaccination Status for Older Adults
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- Preventive Care and Screening: Influenza Immunization
- Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Communication & Care Coordination (5 Measures)

- Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions Adult Kidney Disease: Referral to Hospice*
- Care Plan*
- Dementia: Caregiver Education and Support*
- Falls: Plan of Care*
- Pain Assessment and Follow-Up*

Clinical Practice Improvement Activities

The Wellbox CCM program can help meet 35 activity measures, including 4 high-priority activities (*), in 7 subcategories

Beneficiary Engagement (10 Measures)

- Engage Patients and Families to Guide Improvement in the System of Care*
- Engagement of patients through implementation of improvements in patient portal
- Engagement of Patients, Family, and Caregivers in Developing a Plan of Care
- Evidenced-based techniques to promote self-management into usual care
- Implementation of condition-specific chronic disease self-management support programs
- Improved Practices that Disseminate Appropriate Self-Management Materials
- Integration of patient coaching practices between visits
- Use evidence-based decision aids to support shared decision-making
- Use of certified EHR to capture patient reported outcomes
- Use of tools to assist patient self-management

Achieving Health Equity (1 Measure)

- Promote Use of Patient-Reported Outcome Tools*

Behavioral & Mental Health (5 Measures)

- Depression screening
- Diabetes screening
- Tobacco use
- Unhealthy alcohol use
- Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients*

Expanded Practice Access (1 Measure)

- Use of telehealth services that expand practice access

Care Coordination (4 Measures)

- Care coordination agreements that promote improvements in patient tracking across settings
- Care transition documentation practice improvements
- Care transition standard operational improvements
- Implementation of practices/processes for developing regular individual care plans

Patient Safety & Practice Assessment (3 Measures)

- Implementation of fall screening and assessment programs
- Use of decision support and standardized treatment protocols
- Use of Patient Safety Tools

Population Management (11 Measures)

- Advance Care Planning
- Chronic Care and Preventative Care Management for Empaneled Patients
- Engagement of community for health status improvement
- Glycemic management services*
- Glycemic Referring Services
- Glycemic Screening Services
- Implementation of episodic care management practice improvements
- Implementation of medication management practice improvements
- Implementation of methodologies for improvements in longitudinal care management for high risk patients
- Provide Clinical-Community Linkages
- Use of toolsets or other resources to close healthcare disparities across communities

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Preventative Care Management

Maximize MIPS Scores Through **Annual Wellness Visits**

Preventive care, such as Annual Wellness Visits (AWV), can help patients avoid preventable illness with proactive measures and access to resources and information. AWV allows physicians to provide a wider variety of care offerings and achieve high MIPS performance scores in the process.

Quality Measures
(most heavily-weighted category)

The Wellbox PCM program can help meet 38 measures, including 11 high-priority measures (*), in all six of the Quality Measure domains

Effective Clinical Care (16 Measures)

- Adult Kidney Disease: Blood Pressure Management*
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users
- Anti-Depressant Medication Management
- Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Controlling High Blood Pressure*
- Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management
- Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy Neurological Evaluation
- Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention Evaluation of Footwear
- Diabetes: Eye Exam
- Diabetes: Foot Exam
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)*
- Hypertension: Improvement in Blood Pressure*

Communication & Care Coordination (8 Measures)

- Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions*
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
- Care Plan
- Closing the Referral Loop: Receipt of Specialist Report
- Colonoscopy Interval for Patients with a History of Adenomatous Polyps
- Dementia: Caregiver Education and Support
- Falls: Plan of Care
- Functional Outcome Assessment

Community/Population Health (7 Measures)

- Pneumococcal Vaccination Status for Older Adults
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- Preventive Care and Screening: Influenza Immunization
- Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Efficiency & Cost Reduction (2 Measures)

- Age Appropriate Screening Colonoscopy
- Medication Management for People with Asthma*

Person & Caregiver-Centered Experience & Outcomes (1 Measure)

- Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older*

Patient Safety (4 Measures)

- Documentation of Current Medications in the Medical Record*
- Elder Maltreatment Screen and Follow-Up Plan*
- Falls: Risk Assessment*
- Falls: Screening for Future Fall Risk*

Clinical Practice Improvement Activities

The Wellbox PCM program can help meet 37 activity measures, including 5 high-priority activities (*), in 7 subcategories

Achieving Health Equity (1 Measure)

- Promote Use of Patient-Reported Outcome Tools*

Behavioral and Mental Health (7 Measures)

- Depression screening
- Diabetes screening
- Implementation of Integrated Patient Centered Behavioral Health Model*
- MDD prevention and treatment interventions
- Tobacco use
- Unhealthy alcohol use
- Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients*

Care Coordination (4 Measures)

- Care coordination agreements that promote improvements in patient tracking across settings
- Care transition documentation practice improvements
- Care transition standard operational improvements
- Implementation of practices/processes for developing regular individual care plans

Beneficiary Engagement (10 Measures)

- Engage Patients and Families to Guide Improvement in the System of Care*
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- Integration of patient coaching practices between visits
- Use evidence-based decision aids to support shared decision-making
- Use of certified EHR to capture patient reported outcomes
- Use of tools to assist patient self-management

Expanded Practice Access (1 Measure)

- Use of telehealth services that expand practice access

Population Management (11 Measures)

- Advance Care Planning
- Chronic Care and Preventative Care Management for Empaneled Patients
- Engagement of community for health status improvement
- Glycemic management services*
- Glycemic Referring Services
- Glycemic Screening Services
- Implementation of episodic care management practice improvements
- Implementation of medication management practice improvements
- Implementation of methodologies for improvements in longitudinal care management for high risk patients
- Provide Clinical-Community Linkages
- Use of toolsets or other resources to close healthcare disparities across communities

Patient Safety & Practice Assessment (3 Measures)

- Implementation of fall screening and assessment programs
- Use of decision support and standardized treatment protocols
- Use of Patient Safety Tools

Key Takeaway

With the leading chronic, preventative and virtual care management solutions in place, practices are better positioned to maximize their MIPS composite score, benefit from positive adjustments to their Medicare payments, and prepare for a future focused on outcomes and quality of care improvement.

Out-of-the-Box Care Management Solutions

Wellbox provides comprehensive care management solutions with a team of licensed RNs that leverage our cutting-edge technology to deliver the highest quality of care. We are committed to creating positive healthcare experiences, enhancing patient engagement and driving better outcomes while maximizing efficiencies within your pre-existing workflows and systems.

Contact us to learn more.

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