MU, MACRA, MIPS, MORE...OMG!

Brett Paepke, OD
• Health care providers report quality measures to 3rd parties about health care services provided.

• Quality measures are tools that help 3rd parties assess various aspects of care such as health outcomes, patient perceptions, and organizational structure.

• Allows a statistical assessment of the quality of care you provide to patients
How does quality reporting impact you?

- Directly impacts your reimbursements
  - Successful and optimal quality reporting allows avoidance of negative/downward payment adjustments under:
    - Medicare EHR Incentive Program (MU)
    - Physician Quality Reporting System (PQRS)
    - Value-Based Payment Modifier (VBM)

- Quality reporting data will be publicly available on Physician Compare and other websites
Members in health plans that offer tiered benefits may pay lower copays and coinsurance amounts for services provided by UnitedHealth Premium® Tier 1 physicians.

UnitedHealth Premium® Tier 1 physicians have received the Premium designation for:

- Quality and Cost Efficiency OR
- Cost Efficiency and Not Enough Data to Assess Quality

Learn More
The Physician Quality Reporting System (PQRS) is a quality reporting program that encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare.

Methods of reporting for PQRS
- Claims-Based Reporting
- Electronic Reporting Using CEHRT
- Registry Reporting
- Qualified Clinical Data Registry Reporting
- Group Practice Reporting Option Web Interface
• Measures and Outcomes Registry for Eyecare
• Started by AOA in response to growing emphasis on quality reporting
• Benefits
  • Outcomes tracking
  • Peer comparisons / benchmarking

<table>
<thead>
<tr>
<th>Patient Safety</th>
<th>Rate</th>
<th>Count</th>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS68</td>
<td>55%</td>
<td>520 / 992</td>
<td>18</td>
</tr>
<tr>
<td>Documentation of Current Medications in the Medical Record</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

• Professional advocacy
• PQRS satisfaction
• Methods of reporting for PQRS
  • Claims-Based Reporting
    • Requirement: report on at least 9 measures spanning 3 domains in more than 50% of eligible cases
    • RevolutionEHR users can add PQRS codes to encounters via the PQRS Alert link on the Coding screen:
Methods of reporting for PQRS

• **Claims-Based Reporting**

  • **Challenges**
    
    • Reporting on at least 9 measures in more than 50% of eligible cases is not easy
    
    • Highly administrative task that providers shouldn’t have to worry about as they’re concluding an encounter
    
    • Not as accurate as electronic reporting as it shows what a provider *said* they did vs. what the record *shows* they did
    
    • Subject to human error
Methods of reporting for PQRS

- **Electronic Reporting Using Certified EHR Technology (EHR Direct)**
  - **Requirement**: report on 9 measures from 3 domains with at least one measure having at least 1 Medicare patient in the denominator
  - **Benefits**
    - lower bar for penalty avoidance
    - easier as clinical quality measure (CQM) scores are tracked automatically via the EHR
    - more efficient
    - one submission of scores can be used to satisfy multiple quality reporting programs (MU, PQRS, VBM)
Methods of reporting for PQRS

Electronic Reporting Using Certified EHR Technology (EHR Direct)

CQM Example:

Documentation of Current Medications in the Medical Record

**Denominator**: encounters with patients 18+ during reporting period

**Numerator**: encounters in the denominator that had the active medication list reviewed as indicated by clicking “Review” on the medications screen
Conclusions

- PQRS must be satisfied to avoid penalties
- Claims-based reporting is the most challenging method and likely to be retired by CMS in the near future
- RevolutionEHR users can consider electronic reporting
The Value-Based Payment Modifier is a program that provides for differential payment (down or up) to a physician or group of physicians based upon the quality of care furnished compared to the cost of care during a performance period.

How does the Value-Based Payment Modifier program determine quality?

- PQRS performance/scoring
  - higher PQRS scores = higher quality
  - lack of PQRS participation = automatic 2% downward adjustment under Value-Based Payment Modifier (total of 4-6% depending on size of practice)
<table>
<thead>
<tr>
<th>Cost of Care</th>
<th>Quality of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Quality</td>
<td>Low Cost</td>
</tr>
<tr>
<td>Average Quality</td>
<td>Average Cost</td>
</tr>
<tr>
<td>High Quality</td>
<td>High Cost</td>
</tr>
</tbody>
</table>

- **High Cost, Low Quality**
- **High Cost, Average Quality**
- **High Cost, High Quality**
- **Average Cost, Low Quality**
- **Average Cost, Average Quality**
- **Average Cost, High Quality**
- **Low Cost, Low Quality**
- **Low Cost, Average Quality**
- **Low Cost, High Quality**
### 2018 Penalties Based on 2016 Performance

<table>
<thead>
<tr>
<th>Provider’s Normal Medicare Payments</th>
<th>2018 Penalty for no MU in 2016 (3%)</th>
<th>2018 Penalty for no PQRS in 2016 (2% + 2%)</th>
<th>Total 2018 Penalty for no MU and PQRS in 2016 (7%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>$300</td>
<td>$400</td>
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<tr>
<td>$50,000</td>
<td>$1,500</td>
<td>$2,000</td>
<td>$3,500</td>
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</tbody>
</table>
MACRA

- **Medicare Access and CHIP Reauthorization Act of 2015**
  - Repeals the Sustainable Growth Rate formula
  - Changes the way that Medicare rewards providers for value over volume
  - Streamlines multiple quality reporting programs under the Quality Payment Program

There are 3 groups of clinicians who will NOT be subject to MIPS:

- **FIRST year of Medicare Part B participation**
- Below low patient volume threshold
- Certain participants in ADVANCED Alternative Payment Models

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year
The Merit-Based Incentive Payment System (MIPS)

- Starts in 2019 based on 2017 performance
- Eliminates the separate penalties of each quality reporting program (MU, PQRS, VM) and, instead, assigns the provider a composite score of 0-100 based on performance in four key areas:
  - Advancing Care Information (MU)
  - Quality (PQRS)
  - Resource Use (Value-Based Payment Modifier)
  - Clinical Practice Improvement Activities

2019
The Merit-Based Incentive Payment System (MIPS)

- Composite scores of all providers calculated and compared

- Mean or Median (decision of which not official) becomes the “performance threshold”
  - Providers with composite scores below threshold will experience downward adjustment of their Medicare Part B Fee Schedule
  - Providers with composite scores above threshold will experience upward adjustment of their Medicare Part B Fee Schedule

- Size of payment adjustment depends on how far away from threshold the provider’s composite score is
  - The farther above threshold score, the greater the upward adjustment
  - The farther below threshold score, the greater the downward adjustment
  - Potential for +/- 9% by 2022
The Merit-Based Incentive Payment System (MIPS)
The Merit-Based Incentive Payment System (MIPS)

<table>
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<th>Primary specialty: Optometry</th>
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<tr>
<td>99 PINE ST ALBANY, NY 12207</td>
</tr>
<tr>
<td>Add to My Favorites</td>
</tr>
<tr>
<td><strong>Cost/Quality Rating</strong></td>
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<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>88.65</td>
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<tr>
<td>75.20</td>
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<tr>
<td>45.25</td>
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</table>
Satisfactory participation is required to avoid penalties, maximize reimbursements and ensure access to patients.

The better your performance, the better your chances for increased reimbursements in the future.

Providers who proactively work toward not only satisfying reporting requirements, but also excelling, will be well-positioned for future success.

But How?
But How?

- Self-guided approach
  - resources on Insight (http://insight.revolutionehr.com)
  - Meaningful Use, PQRS, VBM, MIPS resource pages
  - recorded webinars
  - official CMS resources
RevAspire is a technology-enabled service that supports, equips and assists customers through the entire process of CMS quality reporting.

RevAspire frees you and your staff from the administrative burden of submitting quality reporting data and equips customers with one-on-one support to not just meet CMS quality reporting requirements, but to exceed them.

Three primary services:
1. Quality Reporting Data Submission
2. Personal Quality Reporting Advisor
3. Quality Reporting Audit Response Assistance
Questions?

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Next – 10:15 - 10:45 Break

• 10:45 - Closing Session
connect. learn. advance.