A REVIEW OF MIPS, PQRS, VALUE BASED MODIFIERS, AND MU FOR 2016 AND BEYOND

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AOA MEETING JUNE 2016

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AOA THIRD PARTY CENTER CODING EXPERTS

Rebecca Wartman OD  Douglas Morrow OD  Harvey Richman OD

WHAT WE WILL COVER

• BRIEF OVERVIEW
• THE ECONOMIC VALUE OF HEALTH AND HEALTHCARE-VALUES, PERCEPTIONS AND ATTITUDES
• CURRENT PQRS PROGRAM VS MIPS BEYOND 2016
• SUCCESS AND PENALTIES
• CURRENT EHR & CQM 2015-16 VS MIPS
  • NEW GUIDANCE RELEASED OCT 1, 2015 SUCCESS AND PENALTIES
• CURRENT VALUE BASED MODIFIERS VS MIPS
• SUCCESSES AND PENALTIES
• OTHER RELATED INFORMATION
• RESOURCES

BUT NOT YOUR TYPICAL LECTURE

• GET OUT YOUR CELL PHONES, LAPTOPS OR ELECTRONICS OF CHOICE...

• QUESTIONS FIRST
• THEN DISCUSSION OF ANSWERS TO HELP YOU UNDERSTAND CONCEPTS...AS NECESSARY

• HERE'S HOW...
• [INSERT DIRECTIONS]
QUESTION 1
WHY DOES MEDICARE THINK IT IS NECESSARY TO CHANGE THE CURRENT PAYMENT SYSTEM?
A. IT IS RUNNING OUT OF MONEY
B. IT IS RUNNING OUT OF PROVIDERS
C. IT IS PROVIDING TOO MANY RUNNERS
D. IT WANTS TO PROVIDE VALUE

PLEASE ENTER YOUR RESPONSE NOW!

THE EMERGING VALUE CONTEXT
• RISING COSTS
• RISING COST SHIFTING TO CONSUMERS
• EVIDENCE THAT INNOVATION MAKES A DIFFERENCE
• POTENTIAL PARADIGM EMERGING
  • HIGH COST, HIGH EFFICACY, HIGH CUSTOMIZATION BUT UNAFFORDABLE
• THE QUEST FOR VALUE
  • IOM: BALANCING COST, QUALITY, ACCESS AND EQUITY
  • EVIDENCE BASED MEDICINE AND EVIDENCE BASED BENEFIT DESIGN
• PAY FOR PERFORMANCE
• VALUE PURCHASING

ATTITUDES TOWARD VALUE
• STRONG ARGUMENT → AMERICAN HEALTHCARE IS POOR VALUE
• AMERICANS LOVE HIGH TECHNOLOGY MEDICINE AND THINK, AS A SOCIETY, SHOULD SPEND MORE ON IT…..BUT, OPM (OTHER PEOPLE’S MONEY)
• VALUE IN THE EYE OF THE BEHOLDER …..AND THE PAYER
• VALUE BEING REDEFINED AS WE MOVE TO ENGAGE CONSUMER AS PAYER AND DECISION-MAKER
THE VALUE OF HEALTH CARE
Percentage of consumers rating each of the following a very good or fairly good value

<table>
<thead>
<tr>
<th>Service</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic prescription drugs</td>
<td>63%</td>
</tr>
<tr>
<td>Medical devices</td>
<td>43%</td>
</tr>
<tr>
<td>OTC (non-prescription) drugs</td>
<td>24%</td>
</tr>
<tr>
<td>Doctors</td>
<td>35%</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>12%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>21%</td>
</tr>
<tr>
<td>Brand name prescription drugs</td>
<td>21%</td>
</tr>
<tr>
<td>Health insurance companies</td>
<td>14%</td>
</tr>
</tbody>
</table>

Source: Harris Interactive/Wall Street Journal, Aug 19, 2003

QUESTION 2
HOW DOES THE CURRENT PAYMENT SYSTEM IMPACT YOUR OFFICE?
A. IT PAYS ME FAIRLY FOR WHAT I DO
B. IT PAYS ME TOO MUCH FOR WHAT I DO
C. IT PAYS ME TOO LITTLE FOR WHAT I DO
D. IT PAYS FOR ME TO RETIRE IN THE NEXT FEW MONTHS

PLEASE ENTER YOUR RESPONSE NOW!

CURRENT FEE-FOR-SERVICE MODEL
- MORE WORK WITH LITTLE RETURN
- PAY FOR REPORTING
- MORE COST TO PROVIDER
- LESS TIME WITH PATIENTS MORE PAPERWORK
- TECHNOLOGY IS EXPENSIVE
  - EMR
  - LATEST SCANNING LASER
  - VEP/ERG
  - B SCAN
  - RETINAL IMAGING ETC ETC ETC
WHERE HAVE WE ALREADY BEEN

- Cash Up Front and Little Insurance
- Fee for Service and Usual and Customary Payment
- Higher Your Fees the More You Got Paid
- Fee for Service and Set Fee Schedules
- Carve Out Plans for Vision
- Health Maintenance Organizations
- Gatekeeper Systems
- Medical Homes
- Accountable Care Organizations
QUESTION 3
WHERE DO YOU SEE THIS CONFLICT BETWEEN COST AND QUALITY HEADED?
A. BETTER VALUE  
B. REDUCED OUTCOMES  
C. INCREASED COMPETITION  
D. REDUCED REIMBURSEMENT
PLEASE ENTER YOUR RESPONSE NOW!

MOVING TO VALUE-BASED COMPETITION PROVIDERS
• ACCUMULATE COSTS BY PRACTICE AREA OVER CARE CYCLE  
• BUILD CAPABILITY FOR SINGLE BILLING FOR CYCLES OF CARE, AND BUNDLED PRICING  
• MARKET SERVICES BASED ON EXCELLENCE, UNIQUENESS, & RESULTS AT PRACTICE LEVEL  
• GROW IN AREAS OF STRENGTH - LOCALLY & GEOGRAPHICALLY, USING MEDICALLY INTEGRATED CARE DELIVERY APPROACH

BARRIERS TO VALUE-BASED COMPETITION PROVIDERS
• EXTERNAL  
  • HEALTH PLAN PRACTICES  
  • SUPPLIER MINDSETS  
  • MEDICARE PRACTICES  
  • REGULATIONS  
  • LACK OF RELEVANT INFORMATION  
• INTERNAL  
  • ASSUMPTIONS, MINDSETS, AND ATTITUDES  
  • GOVERNANCE STRUCTURES  
  • MANAGEMENT EXPERTISE  
  • MEDICAL EDUCATION  
  • STRUCTURE OF PHYSICIAN PRACTICE  
  • LACK OF RELEVANT INFORMATION
QUESTION 4

WHAT IS MIPS ANYWAY?
A. MEDICARE INCENTIVE PAYMENT SYSTEM
B. MERIT-BASED INCENTIVE PAYMENT SHARING
C. MEDICARE INCLUDED PAYMENT SERVICES
D. MERIT-BASED INCENTIVE PAYMENT SYSTEM
E. MY INCREDIBLY POOR SENSE OF HUMOR

Quality Payment Program

- Repeals the Sustainable Growth Rate (SGR) Formula
- Streamlines multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- Provides incentive payments for participation in Advanced Alternative Payment Models (APMs)

The Merit-based Incentive Payment System (MIPS)
- First step to a fresh start
- We’re listening and help is available
- A better, smarter Medicare for healthier people
- Pay for what works to create a Medicare that is enduring
- Health information needs to be open, flexible, and user-centric

Advanced Alternative Payment Models (APMs)

Proposed MIPS

- MIPS is a new program
  - Streamlines 3 currently independent programs to work as one and to ease clinician burden.
  - Adds a fourth component to promote ongoing improvement and innovation to clinical activities.
- MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.
QUESTION 5
WHAT ISSUES EXIST FOR YOU WITH THE CURRENT PQRS MODEL?
A. TOO MANY CHOICES
B. NOT ENOUGH OPTIONS
C. HARD TO REMEMBER TO ENTER
D. EMR AUTOCODES INCORRECTLY
PLEASE ENTER YOUR RESPONSE NOW!

PHYSICIAN QUALITY REPORTING SYSTEM
• PQRS BEGAN 2010 - PAY FOR REPORTING PAYING 2% BONUS
• NOW PARTICIPATE TO AVOIDING 2% REDUCTION IN 2018
• CAN BE SUCCESSFUL FOR 2016 CHOICE OF REPORTING METHODS
• STAND ALONE PQRS PROGRAM ENDING IN 2018
• MERIT BASED INCENTIVE PAYMENT SYSTEM (MIPS) BEGINS IN 2019
• MIPS INCORPORATING SOME PQRS REQUIREMENTS

PQRS 2016
• UNSUCCESSFUL IN 2016: PENALIZED 2% IN 2018, NO EXCEPTION
• TOTAL MEDICARE REIMBUREMENT:
  DECREASE 2% + VBM REDUCTIONS (MORE LATER)
QUESTION 6

HOW ARE YOU REPORTING PQRS IN 2016
A. NOT REPORTING
B. CLAIMS BASED REPORTING
C. EHR BASED REPORTING
D. AOA MORE REGISTRY
E. OTHER

PLEASE ENTER YOUR RESPONSE NOW!

PQRS REPORTING OPTIONS

1. CLAIMS BASED REPORTING – TOO LATE FOR 2016 MOST LIKELY
2. QUALIFIED REGISTRY REPORTING
   AOA MORE REGISTRY – BEGINNING IN 2016 (IF REGISTERED BY 2/29/16)
3. MEASURES GROUP REPORTING (2016: NEW ONE APPROPRIATE FOR OD’S!)
4. CERTIFIED ELECTRONIC HEALTH RECORDS REPORTING (CEHRT)
   a. DIRECT PRODUCT SUBMISSION
   b. DATA SUBMISSION
5. QUALIFIED CLINICAL DATA REGISTRY (QCDR)
6. GROUP PRACTICE REPORTING
   a) WEB INTERFACE [25+ EPS IN GROUP]
   b) GROUP REGISTRY REPORTING [2+ EPS]
   c) CMS-CERTIFIED SURVEY VENDOR REPORTING [2+ EPS]
   d) EHR – DIRECT OR DATA SUBMISSION [2+ EPS]
SATISFACTORY 2016 PQRS REPORTING CLAIMS BASED

REPORT 9 (OR MORE) MEASURES – 50% OF APPLICABLE TIME
INCLUDE ONE CROSS CUTTING MEASURE
CROSS-CUTTING = BROADLY APPLICABLE MEASURES

DOES NOT MEAN 9 MEASURES ON EVERY CLAIM AT LEAST 50% OF TIME

CHOOSE MEASURES AND USE THEM AS APPROPRIATE >=50% OF TIME

- SUBMIT PQRS MEASURES FOR ALL REPORTABLE CASES
  PLUS CROSS CUT MEASURE(S) ON ALL CLAIMS
- FREQUENT REPORTING WILL AID IN MEETING THE 50% GOAL
- NO PENALTY FOR MORE FREQUENT REPORTING

2016 PQRS 6 EYE CARE MEASURES

- MEASURE 12 – PRIMARY OPEN ANGLE GLAUCOMA (POAG): OPTIC NERVE EVALUATION (EFFECTIVE CLINICAL CARE)
- MEASURE 14 – AGE-RELATED MACULAR DEGENERATION (AMD): DILATED MACULAR EXAMINATION (EFFECTIVE CLINICAL CARE)
- MEASURE 19 – DIABETIC RETINOPATHY: COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING DIABETES CARE (COMMUNICATION/CARE COORDINATION)
- MEASURE 117 – DIABETES MELLITUS: DILATED EYE EXAM IN DIABETIC PATIENT (EFFECTIVE CLINICAL CARE)
- MEASURE 140 – AGE-RELATED MACULAR DEGENERATION (AMD): COUNSELING ON ANTIOXIDANT SUPPLEMENT (EFFECTIVE CLINICAL CARE)
- MEASURE 141 – PRIMARY OPEN-ANGLE GLAUCOMA (POAG): REDUCTION OF INTRAOCULAR PRESSURE (IOP) BY 15% OR DOCUMENTATION OF A PLAN OF CARE (COMMUNICATION/CARE COORDINATION)

2016-PQRS MEASURES

- DELETED FOR MOST REPORTING METHODS
  - MEASURE 18 – DIABETIC RETINOPATHY: DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY (EFFECTIVE CLINICAL CARE) 2015
  - 2021 F DO NOT REPORT IN 2016 UNLESS YOU ARE REPORTING VIA EHR
  - 8 MEASURES ARE REGISTRY ONLY CODES – SURGEONS ONLY
    - 6 FOR CATARACT & 2 FOR RETINA
    - MEASURE GROUP REPORTING ONLY
    - DO NOT ALLOW USE OF -55 MODIFIER
2016 PQRS

WILL NEED TO REPORT AT LEAST 3 CROSS CUT MEASURES THAT ALLOW USE WITH 92000 CODES

- MEASURE 130 DOCUMENTATION OF CURRENT MEDICATIONS IN THE MEDICAL RECORD (PATIENT SAFETY)
- MEASURE 131 (NQF 0420) PAIN ASSESSMENT AND FOLLOW UP (COMMUNICATION & CARE)
- MEASURE 226 PREVENTIVE CARE AND SCREENING: TOBACCO USE, SCREENING AND CESSATION INTERVENTION (COMMUNITY/POPULATION HEALTH)
- MEASURE 317 PREVENTIVE CARE AND SCREENING: SCREENING FOR HIGH BLOOD PRESSURE AND FOLLOW-UP DOCUMENTED (COMMUNITY/POPULATION HEALTH)

REPORT AT LEAST 3 CROSS CUT MEASURES ON EVERY MEDICARE/RAILROAD MEDICARE PATIENT WHILE 6 EYE CARE MEASURES WILL BE REPORTED AS DIAGNOSIS INDICATES

2016 PQRS

OTHER CROSS CUT MEASURE POSSIBILITIES BUT NOT ALLOWED WITH 92000 CODES

- MEASURE 110 PREVENTIVE CARE AND SCREENING: INFLUENZA IMMUNIZATION [COMMUNITY/POPULATION HEALTH]
- MEASURE 111 PNEUMONIA VACCINATION STATUS FOR OLDER ADULTS [EFFECTIVE CLINICAL CARE]
- MEASURE 128 PREVENTIVE CARE AND SCREENING: BODY MASS INDEX (BMI) SCREENING &FU [COMMUNITY/POPULATION HEALTH]

DIABETIC RETINOPATHY MEASURES GROUP 2016

REGISTRY ONLY AND AOA MORE NOT USING IN 2016

1. DIABETES: HEMOGLOBIN A1C POOR CONTROL (MEASURE 1)
2. DIABETIC RETINOPATHY: DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR EDema AND LEVEL OF SEVERITY OF RETINOPATHy (MEASURE 18)
3. DIABETIC RETINOPATHY: COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING DIABETES CARE (MEASURE 19)
4. DIABETES: EYE EXAM (MEASURE 117)
5. DOCUMENTATION OF CURRENT MEDICATIONS IN THE MEDICAL RECORD (MEASURE 130)
6. PREVENTIVE CARE AND SCREENING: TOBACCO USE, SCREENING AND CESSATION INTERVENTION (MEASURE 226)
7. PREVENTIVE CARE AND SCREENING: SCREENING FOR HIGH BLOOD PRESSURE AND FOLLOW-UP DOCUMENTED (MEASURE 317)

REPORT ALL MEASURES IN MEASURES GROUP FOR AT LEAST 20 PATIENTS-MAJORITY MEDICARE CURRENTLY FOR 92000 AND 99000 CODE SERIES
PROPOSED MIPS QUALITY PERFORMANCE CATEGORY

- Self reported
- Six (6) measures including 1 cross-cutting measure and 1 outcome measure
  - Another high priority measure should be reported if outcome measure is unavailable
  - No domain requirements
  - Population measures automatically calculated

- Will count 50% but more details not yet known

QUESTION 7
WHERE HAVE YOU HAD ISSUES EARNING YOUR EHR BONUS INCENTIVE?
A. Properly applying all measures required
B. Properly applying the security measures
C. EHR vendor properly following through with reporting
D. Failing to properly “click” all required fields so EHR can gather information properly

PLEASE ENTER RESPOND NOW!

QUESTION 8

- Did you know that meaningful use stage 1 & stage 2 were completely revised in October 2015 – replaced with meaningful use modified stage 2?
A. Yes
B. No

PLEASE ENTER RESPOND NOW!
MEANINGFUL USE 2016

• All providers after 1st year of MU must electronically report CQM data
• Reporting period = 12 months 2016 and beyond...but not??
• After 2016, cannot begin to qualify for incentive payments under Medicaid program but incentives will be paid through 2021
• Must continue to demonstrate MU yearly to avoid payment adjustments in future
• If you skip or fail in any one year, you can begin reporting again
• Penalties increase each year provider does not demonstrate
  • Maximum of 5% of Medicare payments
  • Hardship exemption do exist

MEANINGFUL USE MODIFIED STAGE 2
NEW REQUIREMENTS

• Must achieve Meaningful Use under Modifier Stage 2 Rules
• Required to attest to single set of objectives and measures
• No longer “core” and “menu” objectives
• Now 10 objectives, including one consolidated PH reporting objective
• Significant changes to
  1. Patient electronic access, measure
  2. Secure electronic messaging
  3. Public health reporting
• All Medicare physicians must attest by February 28, 2017

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 1: PROTECT PATIENT HEALTH INFORMATION

• Conduct/review security risk analysis in accordance with requirements
• Implement security updates as needed
• Correct identified security deficiencies for risk management process
• No exclusions or exceptions
MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 2: CLINICAL DECISION SUPPORT (BOTH MEASURES)

MEASURE 1

- IMPLEMENT 5 CLINICAL DECISION SUPPORT INTERVENTIONS RELATED TO 4 + CQM
  ENTIRE EHR REPORTING PERIOD (IF 4 CQM NOT APPLICABLE → MUST BE RELATED TO
  HIGH PRIORITY HEALTH CONDITIONS)

MEASURE 2

- ENABLE/IMPLEMENT FUNCTIONALITY FOR DRUG-DRUG & DRUG-ALLERGY CHECKS FOR
  EHR REPORTING PERIOD (EXCLUSION IF WRITE FEWER THAN 100 MEDICATION ORDERS
  FOR EHR REPORTING PERIOD)

OBJECTIVE 3: COMPUTERIZED PROVIDER ORDER ENTRY (SATISFY 3 MEASURES)

MEASURE 1:

- >60% MEDICATION ORDERS RECORDED USING COMPUTERIZED PROVIDER ORDER ENTRY
  EXCLUSION: <100 RX DURING EHR REPORTING

MEASURE 2:

- >30% LAB ORDERS CREATED USING COMPUTERIZED PROVIDER ORDER ENTRY

MEASURE 3:

- >30% RADIOLOGY ORDERS CREATED USING COMPUTERIZED PROVIDER ORDER ENTRY
  EXCLUSION 2 & 3: <100 ORDERS FOR EHR REPORTING PERIOD

OBJECTIVE 4: ELECTRONIC PRESCRIBING

- >50% OF PERMISSIBLE RX WRITTEN ARE QUERIED FOR DRUG FORMULARY AND
  ELECTRONICALLY TRANSMITTED USING CEHRT
  EXCLUSION: <100 RX DURING REPORTING OR NO PHARMACY WITHIN 10 MILES WHO
  EXCEPT ELECTRONIC RX AT BEGINNING OF REPORTING PERIOD
MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 5: HEALTH INFORMATION EXCHANGE
TRANSITIONS/REFERS PATIENT TO ANOTHER CARE SETTING OF CARE/PROVIDER MUST:
1. USE CEHRT TO CREATE SUMMARY OF CARE RECORD
2. ELECTRONICALLY TRANSMIT SUMMARY TO RECEIVING PROVIDER FOR >10 PERCENT OF
   TRANSITIONS OF CARE/REFERRALS
EXCLUSION: TRANSFERS PATIENT TO ANOTHER SETTING/REFERS <100 TIMES FOR EHR
   REPORTING PERIOD

OBJECTIVE 6: PATIENT SPECIFIC EDUCATION
PROVIDE PATIENT SPECIFIC EDUCATION RESOURCES IDENTIFIED BY CEHRT > 10 %
OF UNIQUE PATIENT OFFICE VISITS SEEN BY PHYSICIAN DURING EHR REPORTING
PERIOD
EXCLUSION: NO OFFICE VISITS DURING EHR REPORTING PERIOD

OBJECTIVE 7: MEDICATION RECONCILIATION
PERFORMS MEDICATION RECONCILIATION FOR >50 PERCENT OF TRANSITIONS OF
CARE WHERE PATIENT IS TRANSITIONED INTO CARE OF EP
EXCLUSION: IF NOT RECIPIENT OF ANY TRANSITIONS OF CARE DURING EHR
REPORTING PERIOD
MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 8: PATIENT ELECTRONIC ACCESS

MEASURE 1:
>50 PERCENT OF UNIQUE PATIENTS SEEN DURING EHR REPORTING PERIOD HAS TIMELY ACCESS VIEW ONLINE, DOWNLOAD, & TRANSMIT TO THIRD PARTY THEIR HI SUBJECT TO PHYSICIAN'S DISCRETION TO WITHHOLD CERTAIN INFORMATION NO EXCEPTIONS

MEASURE 2:
AT LEAST 1 PATIENT SEEN DURING EHR REPORTING PERIOD VIEWS, DOWNLOADS OR TRANSMITS TO THIRD PARTY HI DURING EHR REPORTING PERIOD

EXCLUSIONS: PHYSICIAN NEITHER ORDERS/CREATES ANY OF INFORMATION LISTED AS PART OF MEASURES OR CONDUCTS >/= 50% ENCOUNTERS IN COUNTY WITHOUT >/= 50 HOUSEHOLDS W/ 4MBPS BROADBAND AVAILABILITY PER FCC ON DAY 1 EHR REPORTING PERIOD

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 9: SECURE MESSAGING

CAPABILITY FOR PATIENTS TO SEND/RECEIVE SECURE ELECTRONIC MESSAGE WITH PHYSICIAN WAS FULLY ENABLED DURING EHR REPORTING PERIOD

EXCLUSION: NO OFFICE VISITS DURING EHR REPORTING PERIOD, OR >/= 50% OF ENCOUNTERS IN COUNTY WITHOUT >/= 50 HOUSEHOLDS WITH 4MBPS BROADBAND AVAILABILITY ACCORDING TO FCC DAY 1 OF EHR REPORTING PERIOD

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 10: PUBLIC HEALTH REPORTING (MUST MEET 2/3)

MEASURE OPTION 1 – IMMUNIZATION REGISTRY REPORTING:
ACTIVE ENGAGEMENT WITH PH AGENCY TO SUBMIT IMMUNIZATION DATA

EXCLUSIONS: DOES NOT ADMINISTER ANY IMMUNIZATIONS TO POPULATIONS WHERE DATA IS COLLECTED OR NO IMMUNIZATION REGISTRY/IMMUNIZATION INFORMATION SYSTEM MEETING STANDARDS REQUIRED BY CEHRT DEFINITION ON DAY 1 EHR REPORTING PERIOD OR IN JURISDICTION WITHOUT IMMUNIZATION REGISTRY/IMMUNIZATION INFORMATION SYSTEM THAT HAS DECLARED READINESS AT START OF EHR REPORTING PERIOD
MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 10: PUBLIC HEALTH REPORTING
MEASURE OPTION 2 – SYNDROMIC SURVEILLANCE REPORTING:
ACTIVELY ENGAGED WITH PH AGENCY TO SUBMIT SYNDROMIC SURVEILLANCE DATA

EXCLUSION: NOT PROVIDERS WHERE AMBULATORY SYNDROMIC SURVEILLANCE DATA IS COLLECTED OR WHERE NO PUBLIC HEALTH AGENCY CAPABLE OF RECEIVING ELECTRONIC SYNDROMIC SURVEILLANCE DATA AS REQUIRED BY CEHRT DEFINITION AT DAY 1 EHR REPORTING PERIOD OR OPERATES IN JURISDICTION WITHOUT READINESS OF PH AGENCY AT START OF EHR REPORTING PERIOD

• AOA MORE CAN ACHIEVE THIS MEASURE OBJECTIVE

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 10: PUBLIC HEALTH REPORTING
MEASURE OPTION 3 – SPECIALIZED REGISTRY REPORTING:
SUBMIT DATA TO SPECIALIZED REGISTRY

EXCLUSIONS: IF EP DOES NOT DIAGNOSE/TREAT ANY DISEASE/CONDITION ASSOCIATED WITH DATA THAT IS COLLECTED SPECIALIZED REGISTRY IN THEIR JURISDICTION DURING EHR REPORTING PERIOD OR NO SPECIALIZED REGISTRY CAN ACCEPT ELECTRONIC REGISTRY TRANSACTIONS AS REQUIRED BY CEHRT DEFINITION AT DAY 1 OF EHR REPORTING PERIOD OR NO SPECIALIZED REGISTRY HAS DECLARED READINESS TO RECEIVE ELECTRONIC REGISTRY TRANSACTIONS DAY 1 OF EHR REPORTING PERIOD

• AOA MORE CAN ACHIEVE THIS MEASURE OBJECTIVE

QUESTION 9
OUT OF THE 64 CLINICAL QUALITY MEASURES, YOU CURRENTLY HAVE TO REPORT AT LEAST 9 MEASURES. AS OPTOMETRIST, HOW MANY CHOICES DO YOU REALISTICALLY HAVE?
A. 64
B. 24
C. 14
D. 9

PLEASE ENTER RESPONSE NOW!
CLINICAL QUALITY MEASURES

• NO THRESHOLDS TO MEET—SIMPLY HAVE TO REPORT DATA ON CQM

• NO CALCULATIONS FOR CQM!

• CERTIFIED EHR WILL PRODUCE

BUT MUST ENTER DATA EXACTLY AS YOUR CERTIFIED EHR PRODUCED IT SO IT IS REPORTED PROPERLY

CQM 2016 MODIFIED STAGE 2

• MUST REPORT ON 9/64 APPROVED CQMS

• RECOMMENDED CORE CQMS ENCOURAGED BUT NOT REQUIRED

• 9 CQMS FOR ADULT POPULATION (MANY NOT APPROPRIATE FOR OPTOMETRY PRACTICE)

• 9 CQMS FOR Pediatric POPULATION

• NQF 0018 STRONGLY ENCOURAGED SINCE CONTROLLING BLOOD PRESSURE IS HIGH PRIORITY GOAL IN MANY NATIONAL HEALTH INITIATIVES

• CANNOT BE EXCLUDED FROM REPORTING 9 CQM BUT ZERO IS AN ACCEPTABLE VALUE TO REPORT HOWEVER, FOR PQRS EHR REPORTING OPTION, YOU MUST REPORT AT LEAST 1 MEASURE TO MEET PQRS REQUIREMENTS

QUESTION 10

WHAT CPT CODES TRIGGER CQMS?

A. 60000
B. 92000
C. 99000
D. B & C
E. ALL OF THE ABOVE
CQM 2016: FOR 92000 CODES
1. PREVENTIVE CARE AND SCREENING: TOBACCO USE: SCREENING AND CESSION INTERVENTION (POPULATION/PUBLIC HEALTH)
2. DIABETES: EYE EXAM (CLINICAL PROCESS/EFFECTIVENESS)
3. PRIMARY OPEN-ANGLE GLAUCOMA (POAG): OPTIC NERVE EVALUATION (CLINICAL PROCESS/EFFECTIVENESS)
4. DIABETIC RETINOPATHY: DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY (CLINICAL PROCESS/EFFECTIVENESS)
5. DIABETIC RETINOPATHY: COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING DIABETES CARE (COMMUNICATION/CARE COORDINATION)
6. DOCUMENTATION OF CURRENT MEDICATIONS IN THE MEDICAL RECORD (PATIENT SAFETY)
7. CLOSING THE REFERRAL LOOP: RECEIPT OF SPECIALIST REPORT (CARE COORDINATION)
8. HEMOGLOBIN A1C TEST FOR Pediatric PATIENTS (CLINICAL PROCESS/EFFECTIVENESS)
9. PREVENTIVE CARE AND SCREENING: SCREENING FOR HIGH BLOOD PRESSURE AND FOLLOW UP DOCUMENTED (POPULATION/PUBLIC HEALTH)

CQM 2016: FOR 99000 CODES ONLY
1. PREVENTIVE CARE AND SCREENING: BODY MASS INDEX (BMI) SCREENING AND FOLLOW-UP PLAN (POPULATION/PUBLIC HEALTH)
2. IMPROVEMENT IN BLOOD PRESSURE (CLINICAL PROCESS/EFFECTIVENESS)
3. CONTROLLING HIGH BLOOD PRESSURE (CLINICAL PROCESS/EFFECTIVENESS)
4. PREVENTIVE CARE AND SCREENING: INFLUENZA IMMUNIZATION (POPULATION/PUBLIC HEALTH)
5. PNEUMONIA VACCINATION STATUS FOR OLDER ADULTS (CLINICAL PROCESS/EFFECTIVENESS)
PROPOSED MIPS EHR MU CHANGES

• ADVANCING CARE INFORMATION PERFORMANCE CATEGORY
  • COUNTS FOR 25% OF TOTAL MIPS SCORE

BASE SCORE + PERFORMANCE SCORE + BONUS POINT = COMPOSITE SCORE
50 POINTS + 80 POINTS + UP TO 1 POINT => 100 POINTS \rightarrow 25%

The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points.

ADVANCING CARE INFORMATION PERFORMANCE CATEGORY (ACIPC)

• BASE SCORE = 50 POINTS

To receive the base score, physicians must simply provide the numerator/denominator or yes/no for each objective and measure.

CMS proposes six objectives and their measures that would require reporting for the base score:

- Protect Patient Health Information (yes required)
- Electronic Prescribing (numerator/denominator)
- Patient Electronic Access (numerator/denominator)
- Coordination of Care Through Patient Engagement (numerator/denominator)
- Health Information Exchange (numerator/denominator)
- Public Health and Clinical Data Registry Reporting (yes required)
ADVANCING CARE INFORMATION PERFORMANCE CATEGORY (ACIPC)

• PERFORMANCE SCORE = 80 POINTS

Physicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

- Patient Electronic Access
- Coordination of Care Through Patient Engagement
- Health Information Exchange

PROPOSED MIPS CHANGES

• NO STAND ALONE CQM REPORTING
• INCORPORATED INTO ADVANCING CARE INFORMATION PERFORMANCE CATEGORY WITH SOME MEASURES PUT INTO THE NEW CATEGORY OF CLINICAL PRACTICE IMPROVEMENT

PROPOSED MIPS: CLINICAL PRACTICE IMPROVEMENT

COULD INCLUDE CARE COORDINATION, SHARED DECISION MAKING, SAFETY CHECKLISTS, EXPANDED PRACTICE ACCESS

Summary:

✓ To not receive a zero score, a minimum selection of one CQA activity (from 90+ proposed activities) with additional credit for more activities
✓ Full credit for patient-centered medical home
✓ Minimum of half credit for APM participation
✓ Key Changes from Current Program:
  • Not applicable (new category)
  • Year 1 Weight: 15%
The Value Based Modifier is:

A. Added to every claim you file
B. Added to every Medicare claim you file
C. Not a billing modifier
D. Calculated by CMS based on your PQRS participation
E. C & D

Please enter response now!

Value Based Modifier (VBM)

What it is NOT
- Not a coding modifier added to claims

What it IS
- Compilation of quality and efficiency data
- Impacts all Medicare physicians
- Began in 2015 (yes last year) & will impact majority of optometrists
- 2018 reimbursement impact based on 2016 performance
- Compiles individual physician's care costs compared to outcomes
- At risk for being paid less than usual Medicare fee-for-service rates
VALUE BASED MODIFIER (VBM)

• **How** VBM Impact is Determined?
  CMS Analysis for Physician’s Score Categorized:
  1. **Quality**: Low Quality, Average Quality or High Quality.
  2. **Cost**: Low Cost, Average Cost, High Cost.
  Physicians will receive reimbursement based on score:
  a) Increase Reimbursement
  b) No change in reimbursement
  c) Reimbursement penalty

VBM 2016

• What to do in 2016 to avoid VBM payment penalties in 2018??
  • Participate and meet PQRS in 2016!
  • Where have you heard this over and over again????
• From 2015 and on:
  • If do not participate in PQRS, then both PQRS Penalty and VBM Penalty
    PQRS Penalty = 2%  
    VBM Penalty:
    • Solo and 2 to 9 EPS Groups Penalty = 2% → **TOTAL 4%**
    • 10 + EPS Groups Penalty = 4% → **TOTAL 6%**

Proposed MIPS Changes - Resources

• Final category to consider is cost replacing current VBM program.
• CMS will calculate based on claims
• Provider does not submit anything
• CMS takes the average of all cost measures available
• Cost is 10% of the final performance weighted score
SUMMARY OF 2016 PENALTIES

- PQRS FAILURE TO PARTICIPATE: -2% MPFS
- MEDICARE EHR MEANINGFUL USE FAILURE: -3% MPFS
- VALUE BASED MODIFIER NON-PQRS PARTICIPANTS
  - NON-PQRS SOLO AND 2-9 PROVIDER GROUPS: -2% MPFS
  - NON-PQRS 10+ PROVIDER GROUPS: -4% MPFS
- VALUE BASED MODIFIER PQRS PARTICIPANTS
  - PQRS SOLO AND 2-9 PROVIDER GROUPS: -2X MPFS (X=QUALITY TIERING)
  - PQRS 10+ PROVIDER GROUPS: -4X MPFS (X=QUALITY TIERING)

GROUPS/SOLO ELIGIBLE FOR EXTRA +1X MPFS IF IN TOP 25% QUALITY TIERING

POTENTIAL TO LOSE 7-9% OF YOUR MEDICARE REIMBURSEMENT AND 2% SEQUESTRATION DUE TO SEQUESTRATION!
REAL IMPACT OF MIPS ON REIMBURSEMENT

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

- MIPS composite performance scoring method that accounts for:
  - Weights of each performance category
  - Exceptional performance factors
  - Availability and applicability of measures for different categories of clinicians
  - Group performance
  - The special circumstances of small practices, practices located in rural areas, and non-patient-facing MIPS eligible clinicians

PROPOSED RULE

REAL IMPACT OF MIPS ON REIMBURSEMENT

- Potential for adjustment

QUESTION 12

WHAT IS THE MOST COMMON MEANINGFUL USE AUDIT ISSUE?
A. COMPUTER SECURITY
B. IGNORING AUDIT REQUEST
C. FAILURE TO COMPLETE THE CQM REQUIREMENTS
D. NEVER HAD AN AUDIT

PLEASE RESPOND NOW!
Attestation Approved Email

CMS Medicare EHR Incentive Program Attestation Status Update
mailto:benf@benfhlalease.com
Sent: Thursday, January 28, 2016 11:00 AM
To: m@meaningfuluse.com
This email is to inform you that your Attestation for the Medicare Electronic Health Record (EHR) Incentive Program is Approved!

Attestation Tracking Information

Attestation Confirmation Number: 3889009988
Name: Harvey R Richman
NPI: 1599134405
EHR Certification Number: 520600712094
EHR Reporting Period: 01/01/2015 - 12/31/2015
Program Year: 2015
Attestation Status: Approved

The attestation demonstrates meaningful use of certified EHR technology.

CMS Changes Requirements due to Audits

Meaningful Use Measure 8A-View, download & transmit patient information
CMS-14092-EMVRC
Sent: Tuesday, February 23, 2016 2:36 PM
To: DR RICHMAN

Dear Provider:

Under the EHR Incentive Programs, Objective 8 is to provide patients the ability to view, download or transmit their health information within 4 business days of the information being available to the eligible professional/EP. There are two measures for this objective and both provide the following exclusion: “Any EP who - neither orders nor creates any of the information listed for inclusion as part of the measures except for ‘Patient Name’ and ‘Provider’s name and office contact information.’”

CMS has corrected an error in the Registration and Attestation (R&A) system which did not allow an EP to claim the exclusion for Objective 8: Patient Electronic Access, measure 1 (referred to as 8A in the atestation system). This oversight has led to the rejection of atestations.

CMS corrected this error on February 21, 2016. You are being contacted because your attestation was rejected. If you intended to claim this exclusion for the first time, Objective 8, you should return to the R&A system and modify your attestation. After selecting the exclusion, please make certain to click the button to resubmit your attestation.

AUDIT NOTICE EMAIL ONLY

FROM: MEANINGFUL USE (FIGLIOZZI & CO.)
SUBJECT: HITECH MEANINGFUL USE PREPAYMENT AUDIT FOR DR. RICHMAN (NPI#1154306264) IMPORTANCE: HIGH

SELECTED BY CMS FOR A HITECH EHR MEANINGFUL USE PREPAYMENT AUDIT FOR PAYMENT YEAR 3. SINCE THIS IS A PREPAYMENT AUDIT YOUR INCENTIVE PAYMENT WILL BE HELD PENDING THE OUTCOME OF THIS AUDIT. WE ARE THE CMS CONTRACTOR AUTHORIZED TO PERFORM THE AUDIT.

PLEASE CONFIRM YOUR RECEIPT OF THIS E-MAIL. ALSO, PLEASE CONFIRM WHETHER YOU WILL BE THE CONTACT PERSON FOR THIS AUDIT. IF YOU WILL BE THE CONTACT PERSON, PLEASE SUPPLY YOUR PREFERRED CONTACT INFORMATION FOR FUTURE CORRESPONDENCE. IF YOU ARE NOT THE CONTACT PERSON FOR THIS AUDIT, PLEASE ADVISE US WHO AT YOUR FACILITY IS THE CORRECT CONTACT PERSON AND FURNISH THEIR E-MAIL ADDRESS.

DEADLINES FOR RESPONDING ALSO LISTED

[Some details and contact information are included here, but not fully transcribed due to page constraints.]
Audit Approval Email

QUESTION 13

WHY IS THE PHYSICIAN COMPARE WEBSITE IMPORTANT AND HOW COULD IT IMPACT YOU?

A. NOT IMPORTANT AND DOES NOT IMPACT ME
B. VERY IMPORTANT BUT HAVE NO IDEA HOW IT IMPACTS ME
C. IMPORTANT AND USED BY PATIENTS TO CHOOSE PROVIDERS
D. VERY IMPORTANT AND TELLS PATIENTS EVERYTHING ABOUT MY PRACTICE

PLEASE RESPOND NOW!

PHYSICIAN COMPARE

Centers for Medicare and Medicaid Services (CMS) website

- Find & choose physicians/other health care professionals enrolled in Medicare
- Can make informed choices about health care you get
  (required by Affordable Care Act (ACA) of 2010)
- Can compare group practices
- Will be able to compare individual physicians and other qualified health care providers (coming)

American Board of Optometry (ABO) Board Certification will be added to Physician Compare website
For physician, other health care professional, or group practice’s information to appear on Physician Compare:

1. Current and “approved” status PECOS Enrollment records
2. Valid physical location or address identified
3. Valid specialty must be identified
4. Professional must have National Provider Identifier (NPI)
5. Individual provider must have submitted at least 1 Medicare Fee-for-Service claim within last 12 months
6. Group practice must have at least 2 approved health care professionals reassigning their benefits to group
QUESTION 14

WHAT IS AOA MORE?
A. AOA ATTEMPT TO COLLECT HIGHER DUES FROM EACH OD
B. AOA CLINICAL DATA REGISTRY
C. AOA FREE MEMBER BENEFIT THAT WILL HELP ME MEET MIPS
D. AOA DATA REGISTRY THAT COSTS MEMBERS AN EXTRA $1800/YEAR
E. B&C

PLEASE RESPOND NOW!

ODS CAN NO LONGER BE EXCLUDED FROM OBJECTIVE 10

OBJECTIVE 10: PUBLIC HEALTH REPORTING (SCHEDULED FOR STAGE 2 - 2015 - MEET 2/3)
MEASURE OPTION 3 – SPECIALIZED REGISTRY REPORTING:

SUBMIT DATA TO SPECIALIZED REGISTRY

EXCLUSIONS: IF EP DOES NOT DIAGNOSE/TREAT ANY DISEASE/CONDITION ASSOCIATED WITH DATA THAT IS COLLECTED SPECIALIZED REGISTRY IN THEIR JURISDICTION DURING EHR REPORTING PERIOD OR NO SPECIALIZED REGISTRY CAN ACCEPT ELECTRONIC REGISTRY TRANSACTIONS AS REQUIRED BY CERHT DEFINITION AT DAY 1 OF EHR REPORTING PERIOD OR NO SPECIALIZED REGISTRY HAS DECLARED READINESS TO RECEIVE ELECTRONIC REGISTRY TRANSACTIONS DAY 1 OF EHR REPORTING PERIOD.
REGISTRIES ARE IMPORTANT TO YOU!

• SIMPLIFIES PQRS
  • 62% OF ODS DID NOT DO PQRS IN 2013
  • GOT PENALIZED IN 2015

IMMEDIATE MU BENEFITS

• MEANINGFUL USE 2016
  • USING AOA MORE QUALIFIES YOU FOR MU IN 2016
  • EVEN IF YOUR VENDOR IS NOT INTEGRATED
  • BY SIGNING UP, YOU WILL QUALIFY!
  • DEADLINE WAS FEB 29, 2016 FOR THIS YEAR

Enrollment Deadline for EHR Incentive Program Participants

FEB 29 2016
OTHER AOA MORE BENEFITS

- Benchmark and Outcomes
  - Helping you in your exam room to see how you compare to ODs across the country
- Advocacy
  - Optometry writes its own script!
  - Gives us information about our own care
- Evidence-Based

COST OF AOA MORE

- $0.00 for AOA Members!
- $0 charged by AOA
  - Compulink is charging $10/month per doc
- No other vendor is charging for your use of AOA More
- $1,800 per year for non-members
RESOURCES

CMS MODIFIED STAGE 2 RESOURCE
HTTP://WWW.CMS.GOV/REGULATIONS-AND-GUIDANCE/LEGISLATION-INCENTIVEPROGRAMS/STAGE_2.HTML

AOA MEANINGFUL USE RESOURCES
HTTP://WWW.AOA.ORG/OPTOMETRISTS/TOOLS-AND-RESOURCES/MEDICAL-RECORDS-AND-CODING/MU

AOA VALUE BASED MODIFIER RESOURCES
HTTP://WWW.AOA.ORG/ADVOCACY/FEDERAL-ADVOCACY/REGULATORY-ISSUES/MEDICARE/CMS-VALUE-BASED-PAYMENT-MODIFIER

AOA ADVOCACY ACO TOOLKIT
HTTP://WWW.AOA.ORG/ADVOCACY/ABOUT-THE-THIRD-PARTY-CENTER/ACO-RESOURCE-TOOLKIT

AOA CODING RESOURCES INCLUDING PQRS
HTTP://WWW.AOA.ORG/CODING

RESOURCES FOR TODAY
HTTP://NJII.COM/MIPS-CALCULATOR/

• CALCULATOR

CONTACTS AND WEBSITES

• MOST MATERIAL REFERENCED ON WEB
• USE AVAILABLE TOOLS
  • CPT, ICD-10-CM, HCPCS
• USE AOA CODING TODAY.COM
  • INSTANT UPDATES
  • EXTRA CODING TOOLS
  • NOTES
  • CLARIFICATIONS
• WWW.AOA.ORG/CODING
**FINAL QUESTION**

WAS THIS FORMAT AND PRESENTATION HELPFUL TO YOU?
A. YES, BOTH WERE HELPFUL AND INTERESTING
B. FORMAT WAS NOT HELPFUL BUT INFORMATION WAS
C. FORMAT WAS HELPFUL BUT INFORMATION WAS NOT
D. BOTH FORMAT AND INFORMATION ARE OVERWHELMING FOR ME
E. WOULD PREFER FORMAL LECTURE FOR INFORMATION BUT INFORMATION WAS HELPFUL
F. NONE OF THE ABOVE

PLEASE ENTER RESPONSE NOW!

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**THANK YOU!!**

REMEMBER YOUR FEEDBACK IS IMPORTANT TO US!!