Quality Reporting Initiatives and ICD-10-CM

Keeping up with the Changes
Agenda

• New ICD-10-CM updates effective on October 1 2016

• 2016 Quality Reporting, next steps for successful PQRS/MU reporting

• 2017 Proposed rule for MACRA and MIPS
ICD-10-CM Updates
On October 1, 2016 there are a number of ICD-10 changes taking place

- The 12 month transitional period ends
- Updates to ICD-10 code set will begin.
- 1,943 new codes, 422 revised and the 305 deleted codes that will take effect.
- Nearly 400 codes affecting the conditions of the eye
- The new codes will increase the level of specificity to a greater degree
- Use of unspecified codes will cause an increase in denials
What You Need to Know

• For all claims with dates of service on or after Oct. 1, 2016, you must use the updated ICD-10 codes. Medicare claims will reject if an outdated code is used.

• Some commercial payers may take longer to update codes. This could result in claims denials and payment delays. Watch claim rejection reports and monitor payers’ websites closely.

• Along with the coding updates, the Official Guidelines for Coding and Reporting have also been updated where necessary.
Glaucoma - Laterality

H40.11X - Primary open-angle glaucoma (7th character required)

H40.11 - Primary open-angle glaucoma (7th)
- H40.111 – Primary open-angle glaucoma, right eye
- H40.112 – Primary open-angle glaucoma, left eye
- H40.113 – Primary open-angle glaucoma, bilateral
- H40.119 – Primary open-angle glaucoma, unspecified eye

0 = stage unspecified
1 = mild stage
2 = moderate stage
3 = severe stage
4 = indeterminate stage
Age-Related Macular Degeneration

Deleted - H35.32 Exudative age related macular degeneration (5 characters)

H35.321 Exudative age-related macular degeneration, right eye
H35.322 Exudative age-related macular degeneration, left eye
H35.323 Exudative age-related macular degeneration, bilateral
H35.329 Exudative age-related macular degeneration, unspecified eye

Added staging codes to the 7th characters to be assigned in subcategory H35.32 to designate the stage of the disease:

0 = stage unspecified
1 = with active choroidal neovascularization
2 = with inactive choroidal neovascularization
3 = with involuted or regressed neovascularization with inactive scar
Exudative Age-Related Macular Degeneration

16 new codes added

H35.3210  Exudative age-related macular degeneration, right eye, stage unspecified
H35.3211  Exudative age-related macular degeneration, right eye, with active choroidal neovascularization
H35.3212  Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization
H35.3213  Exudative age-related macular degeneration, right eye, with inactive scar
H35.3220  Exudative age-related macular degeneration, left eye, stage unspecified
H35.3221  Exudative age-related macular degeneration, left eye, with active choroidal neovascularization
H35.3222  Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization
H35.3223  Exudative age-related macular degeneration, left eye, with inactive scar
H35.3230  Exudative age-related macular degeneration, bilateral, stage unspecified
H35.3231  Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization
H35.3232  Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization
H35.3233  Exudative age-related macular degeneration, bilateral, with inactive scar
H35.3290  Exudative age-related macular degeneration, unspecified eye, stage unspecified
H35.3291  Exudative age-related macular degeneration, unspecified eye, with active choroidal neovascularization
H35.3292  Exudative age-related macular degeneration, unspecified eye, with inactive choroidal neovascularization
H35.3293  Exudative age-related macular degeneration, unspecified eye, with inactive scar
Diabetic Mellitus

E10.32- Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy (with/without macular edema)
E10.33- Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy (with/without macular edema)
E10.34- Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy (with/without macular edema)
E10.35- Type 1 diabetes mellitus with proliferative diabetic retinopathy (with/without macular edema)

One of the following 7th characters is to be assigned to codes in subcategory E10.32 to designate laterality of the disease:

1 = right eye
2 = left eye
3 = bilateral
9 = unspecified eye
Coding guidelines have been updated to accommodate the new or revised codes.

- Review revised instructions in the Tabular list
- Review Exclude 1 and Exclude 2 notes
- Review the “Code First”, “Use additional code” instructions for conditions the that require the underlying condition be sequenced first
Quality Reporting Initiatives 2016
What is Quality Reporting?

• Health care providers report quality measures to CMS about health care services provided.

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

• The measures reported inform CMS on the high-quality of care provided and capture data relate to the goal of effective, safe, efficient, patient-centered, equitable, and timely care.
Quality Reporting Initiatives 2016

Physician Quality Reporting System (PQRS)
  • Based on tax identification number (TIN) and the providers individual NPI

Value-Based Payment Modifier (VM)
  • Based only on tax identification number (TIN)

EHR Meaningful Use incentive Program (MU)
  • Based on the providers individual NPI
Negative Payment Adjustment - 2018

Those who do not satisfactorily report data on quality measures for services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board, and Medicare Secondary Payer) will be subject to a negative payment adjustments.

- PQRS will be subject to a 2% 2018 negative payment adjustment.
- Value-Based Modifier will be subject to 2% to 4% negative payment adjustment
- Meaningful Use will be subject to a 2% negative payment adjustment
2016 Reporting Methods

Providers may choose to report from the following reporting mechanisms to submit data:

- Medicare Part B claims based reporting (PQRS only)
- EHR data submission vendor (DSV) that is CEHRT
- EHR direct product that is CEHRT
- Qualified Registry - AOA MORE, AAO IRIS
2016 PQRS Claims Reporting

- Reporting period for 2016 is a full 12 months (1-1-2016 to 12-31-2016)
- Requirement is to report **9 measures covering at least 3 National Quality Strategy (NQS) domains** of the 6 available domains
- Required to report **one cross-cutting measure** if at least 1 Medicare face to face encounter (found on PECAA website)
- To successfully report must submit data on at least 50% of the patients meeting the measure specifications
- Each measure will state the frequency required to report during the reporting period
The National Quality Strategy (NQS)

The Six NQS Domains are:

- Patient Safety
- Person and Caregiver Centered Experiences and Outcomes
- Communication and Care Coordination
- Effective Clinical Care
- Community Population Health
- Efficiency and Cost Reduction
2016 PQRS Measures

NQS Domain - Effective Clinical Care
• Measure 12 - POAG; Optic Nerve Evaluation
• Measure 14 - AMD; Dilated Macular Examination
• Measure 117 - Diabetes Mellitus: Dilated eye exam
• Measure 140 - AMD: Counseling on Antioxidant Supplement

NQS Domain - Communication & Care Coordination
• Measure 19 - Diabetic Retinopathy: Findings of dilated macular or funds exam communicated with the physician responsible for managing ongoing diabetes care
• Measure 131 - Pain Assessment
• Measure 141 - POAG: Reduction of IOP
2016 PQRS Measures

NQS Domain - Patient Safety
- Measure 130 - Current Medications

NQS Domain - Community / Population Health
- Measure 226 - Patient screened for tobacco use
- Measure 317 - Documented blood pressure reading

✦ Each of these measure and specifications are available on the PECAA website on the Quality Reporting page
2016 PQRS Claims Reporting

To ensure claims data is being processed look for these denial code(s) on the Medicare Remittance Advice

- If billed with $0.00 charge on a quality data code line item will receive an N620 code on the RA

- If billed with a charge of $0.01 on a quality data code item will receive CO 246 N620 on the RA
Feedback Reports PQRS

There is no prior registration is needed to begin reporting.

To review feedback reports during and after reporting will need to register with Quality Net. Complete feedback reports are available in the fall of the following year.

www.qualitynet.org - PQRS
Quality Net Help Desk
7 a.m. - 7 p.m. CT   Monday - Friday
Phone: (866) 288-8912*
CMS has been phasing in the Value Modifier Program since 2013. Starting with medical group practices of 100+ providers.

In 2015 the VBM applied to all physician including solo practitioners, and is based on PQRS performance in the 2015 reporting year. No payment adjustment was applied.

Based on PQRS met performance scores in 2016, upward or downward payment adjustments will apply in 2018 for all providers regardless of specialties and size practices including solo practitioners or in groups of 2 or more.
## Value-Based Modifier

Tiered payment levels based on PQRS & claims data used to compare practice to national average on quality and costs

<table>
<thead>
<tr>
<th>Cost / Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+0.00%</td>
<td>+1.00%</td>
<td>+2.00%</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-1.00%</td>
<td>+0.00%</td>
<td>+1.00%</td>
</tr>
<tr>
<td>High Cost</td>
<td>-2.00%</td>
<td>-1.00%</td>
<td>+0.00%</td>
</tr>
</tbody>
</table>
Meaningful Use - Modified Stage 2

- For the first year of participation the required reporting period is a continuous 90-day period during the calendar year (January 1st to December 31st)
- Returning participates, required reporting period is the entire calendar year. *Proposed reporting period be change to a continuous 90-days
- All providers are required to attest to a single set of **10 objectives and measures.**
- **9 electronic clinical quality measures (eCQM)** covering at least 3 of the 6 National Quality Strategy (NQS) domains
- Your **certified EHR** will help you meet the requirements for Meaningful Use. All certified EHR technology includes functionality that will help you accomplish the objectives and measures that you must meet.
Objectives for 2015 through 2017

Objective 1: Protect Patient Health Information

Explanation: Protect information maintained by the EHR through technical capabilities

- **Measure:** Conduct a security risk analysis and implement security updates as necessary
Objectives for 2015 through 2017

Objective 2: Clinical Decision Support

Explanation: Use clinical decision support to improve performance on high-priority health information

- **Measure 1:** Implement 5 clinical decision support interventions related to 4 or more quality measures at a relevant point in patient care

- **Measure 2:** Enable and implement the functionality for drug to drug and drug allergy interaction checks

- **Exclusion for Measure 2:** If write fewer than 100 medication orders during the reporting year
Objectives for 2015 through 2017

Objective 3: Computerized Provider Order Entry (CPOE)

Explanation: Use CPOE for medication, lab and radiology orders

- **Measure 1**: More than 60% of medication orders created through CPOE
- **Exclusion Measure 1**: Any EP that writes fewer than 100 medication order during the reporting period
- **Measure 2**: More than 30% of lab orders created through CPOE
- **Exclusion Measure 2**: Any EP that writes fewer than 100 lab orders during the reporting period
- **Alternate Exclusion for Measure 2**: Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 2 (lab orders)
Objectives for 2015 through 2017

Objective 3: Computerized Provider Order Entry (CPOE)

- **Measure 3:** More than 30% of radiology orders created through CPOE
- **Exclusion for Measure 3:** Any EP that writes fewer than 100 radiology orders during the report period
- **Alternate Exclusion for Measure 3:** Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 3
Objective 4: Electronic Prescribing

Explanation: Generate and transmit prescriptions electronically

- **Measure:** More than 50% prescriptions are transmitted electronically

- **Exclusions:**
  - Any EP that writes fewer than 100 prescriptions during the reporting period.
  - Does not have a pharmacy within 10 miles of the practice location that accepts electronic prescriptions
Objectives for 2015 through 2017

Objective 5: Health Information Exchange

Explanation: Provide a summary of care record for each transition of care referral

- **Measure:** Use EHR to create a summary of care record/letter and electronically transmit the record to the receiving provider for more than 10% of transition of care and referrals
- **Exclusion:** Any EP who transfers a patient to another provider less than 100 times during the reporting period
Objective 6: Patient Specific Education

Explanation: Use clinically relevant information from EHR to identify patient-specific educational materials or resources to provide to patient

- **Measure**: Patient specific education resources are provided to the patient more than 10% of all unique patient visits seen during the reporting period

- **Exclusion**: Any EP who has no office visits during the reporting period
Objectives for 2015 through 2017

Objective 7: Medication Reconciliation

Explanation: Performs medication reconciliation if relevant

- **Measure:** Performed on more than 50% of patients transitioning care
- **Exclusion:** Any EP who was not been the recipient of any transitions of care during the reporting period
Objective 8: Patient Electronic Access (VDT)

Explanation: Provide patients the ability to view, download, and transmit their information within timely access (4 business days) of the information being available to the EP. Available information is subject to the EPs discretion.

- **Measure 1**: More than 50% of all unique patients are provided timely access to their information
- **Measure 2**: During the reporting period in 2016 at least 1 patient seen by the EP views, downloads or transmits their information to a third party (5% in 2017)
Objective 9: Secure Messaging

Explanation: Use secure electronic messaging to communicate with patients on relevant health information

• Measure: For 2016 at least 1 patient seen by the EP during the reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient, or in response to a secure message sent by the patient
Objective 10: Public Health Reporting

Explanation: Active engagement with a public health agency to submit data. EPs must meet 2 of the 3 measures.

- **Measure Option 1**: Immunization registry reporting
- **Exclusions for Measure 1**: EP does not administer or collect immunization data to report to registry or in which no immunization registry or information system is available
- **Measure Option 2**: Syndromic surveillance reporting
- **Exclusion for Measure 2**: EP does not administer or collect ambulatory syndromic surveillance data or in which no ambulatory syndromic surveillance system is available
Objective 10: Public Health Reporting (cont’d)

- **Measure Option 3**: Specialized registry reporting
- **Exclusion for Measure 3**: EP does not diagnose or treat any disease or condition associated with or collect relevant data that is collected by a specialized registry during the reporting period
Quality and Resource Use Reports (QRUR)

- Each fall CMS put out QRUR feedback reports for the previous calendar year
- QRUR reports will reflect cost and quality data, assigned to your practice
- To access the feedback reports
  
  https://portal.cms.gov
  
  PV-PQRS application on the portal
  
  EIDM Login (previously IACS)
Resources on Meaningful Use

CMS Website


PECAA Website

- List of the Objectives and Measures are also available
Proposed Rules for MACRA and MIPS 2017
The Medicare Access and CHIP Reauthorization Act (MACRA)

- 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
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
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)

- “Pick Your Pace” in 2017
  - **Option 1:** Test the Quality Payment Program
  - **Option 2:** Participate for part of the year
  - **Option 3:** Participate for the full year

- The longer the 2017 reporting period, the higher the potential upward revision of reimbursements in 2019
Advancing Care Information (MU)

- How is ACI different from Meaningful Use?
  - fancy new name!
  - new scoring system
Advancing Care Information (MU)

- What about the objectives?
  - **2017**: clinicians have option of modified Stage 2 objectives or Stage 3 objectives
    - Clinical Decision Support and CPOE optional in proposal
    - Stage 3 requires 2015 certified EHR technology
  - **2018 and beyond**: Stage 3 objectives
Advancing Care Information (MU)

- **Base score**
  - clinicians must report data for each objective
    - a numerator >0 and denominator for %-based measures
    - a “Yes” for Yes/No measures
  - report data for each objective = 50 points
  - don’t report data for each objective = 0 points
Advancing Care Information (MU)

- Performance score
  - built based on actual score across 8 measures
  - each measure counts for a max of 10 points
    - example: 80% for V/D/T Access = 8 points
  - no more targets/thresholds to meet (beyond 1 in the numerator needed to achieve “base” score)
Advancing Care Information (MU)

- What about Public Health Reporting?
  - It’s still one of the 6 included objectives in the “Base” score
  - Immunization registry reporting is required
    - proposal recognizes that not all clinicians administer immunizations. In turn, there’s an allowance to leave this blank during attestation if the previous exclusions apply
  - Syndromic Surveillance & Specialized Registries optional
  - “Active engagement” with a registry beyond Immunizations would result in a bonus point
    - AOA MORE
Advancing Care Information (MU)

- Composite score
  - Base score + Performance score + Bonus Point
    - if score $\geq 100$, you receive the full 25 points
      - ability to score $>100$ gives you flexibility
    - if score is $<100$, you receive a corresponding % of 25 points
      - i.e., Base score of 50 + Performance score of 30 = 80. 80% of 25 points = 20 total points for Advancing Care Information
## Advancing Care Information (MU)

<table>
<thead>
<tr>
<th>Scoring Example 1</th>
<th>Scorecard</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>E-Prescribing</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Patient Electronic Access to Health Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V/D/T Access</td>
<td>80%</td>
<td>8 points</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td>90%</td>
<td>9 points</td>
</tr>
<tr>
<td>Coordination of Care Through Patient Engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V/D/T Actual Use</td>
<td>5%</td>
<td>0.5 points</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>50%</td>
<td>5 points</td>
</tr>
<tr>
<td>Patient-Generated Health Data</td>
<td>1%</td>
<td>0.1 points</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Care Record Exchange</td>
<td>50%</td>
<td>5 points</td>
</tr>
<tr>
<td>Request/Accept Patient Care Record</td>
<td>50%</td>
<td>5 points</td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td>50%</td>
<td>5 points</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

**Base score: 50 points + Performance score: 37.6**

Advancing Care Information score: 87.6% of 25 max points = 21.9 points
## Advancing Care Information (MU)

### Scoring Example 2

<table>
<thead>
<tr>
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<th>Scorecard</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
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**Base score:** 0 points

**Advancing Care Information category score:** 0% of 25 points = 0 points
What’s New?

Clinicians will report on 6 measures (instead of 9 like 2016)
  - 1 cross-cutting measure
  - 1 outcome measure

Increased reporting frequency requirements

Clinicians reporting via electronic methods (EHR, registry, etc.) need to report on at least 90% of patients (Medicare + non-Medicare)

Clinicians reporting via claims need to report on at least 80% of Medicare Part B patients

Evaluated on 8 or 9 measures

Individuals and small groups (2-9 providers) would have two additional population measures determined automatically via claims data. Larger groups (10+) would have three population measures.

active participation on part of clinician not required for this. i.e., no need to add specific codes pertaining to population measures
Quality (PQRS)

• Scoring
  • Each measure worth 10 points for total possible score of 80 or 90 (depending on size of practice)
  • Scores are compared to benchmarks for final performance scoring
    • Not a 1:1 conversion from performance to score like in Advancing Care information
      • 80% performance does not necessarily = 8 points
Quality (PQRS)

- **Example**
  - Diabetes: Eye Exam 90%
  - Closing the Referral Loop 95%
  - Documentation of Current Meds in the Medical Record 90%
  - POAG: Optic Nerve Evaluation 95%
  - Diabetic Retinopathy: +/- DME and Level of Ret 90%
  - Diabetic Retinopathy: Communication with PCP 80%
  - Population Measure 1 75%
  - Population Measure 2 85%

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<th>post-benchmark comparison</th>
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<td>10 points</td>
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<tr>
<td>Population Measure 1</td>
<td>75%</td>
<td>9 points</td>
<td></td>
</tr>
<tr>
<td>Population Measure 2</td>
<td>85%</td>
<td>9 points</td>
<td></td>
</tr>
</tbody>
</table>

Performance score: 70 points. 70 of 80 possible points = 87.5%

Quality category score: 87.5% of 50 points = 43.75 points
Resource Use (Value-based Payment Modifier)

• Clinicians do not need to report anything for this category
• All data for measures within Resource Use calculated from claims information
  • Total per-capita costs for attributed beneficiaries
  • Medicare spending per attributed beneficiaries (hospitalizations)
  • Other episode-based measures
• Provide the care you deem necessary for your patients each at every visit, no more and no less, and your resource use “is what it is”
Clinical Practice Improvement Activities

- Defined by MACRA as activities that are “likely to result in improved outcomes”
- More than 90 proposed activities spanning 9 categories
  - Expanded Practice Access
  - Beneficiary Engagement
  - Achieving Health Equity
  - Population Management
  - Patient Safety & Practice Assessment
  - Emergency Preparedness & Response
  - Care Coordination
  - APM participation
  - Integrated Behavioral and Mental Health
Clinical Practice Improvement Activities

- Each activity is weighted:
  - “High” activity is worth 20 points
  - “Medium” activity is worth 10 points
  - 60 points needed for maximum performance
  - i.e., a clinician could achieve maximum performance via:
    - 3 “high” activities
    - 2 “high” and 2 “medium” activities
    - 6 “medium” activities

- Activities in practices with <15 providers worth 30 points each whether “high” or “medium”

- Must perform activity for at least 90 days during the performance period
Clinical Practice Improvement Activities

• Examples of Activities
  • **Expanded Practice Access**
    • Expanded office hours in evenings and weekends with access to the patient medical record and/or provision of same/next day care for urgent care cases (HIGH)
  • **Population Management**
    • Use of a qualified clinical data registry (i.e. AOA MORE) to generate regular feedback reports that summarize treatment outcomes (HIGH)
  • **Beneficiary Engagement**
    • Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms (MEDIUM)
The Merit-based Incentive Payment System (MIPS)

- ACI: 21.9 points
- Quality: 43.75 points
- Resource Use: 8 points
- CPIA: 15 points

MIPS Composite Score: 88.65

- Advancing Care Information (MU)
- Quality (PQRS)
- Resource Use (Value-Based Payment Modifier)
- Clinical Practice Improvement Activities
The Merit-based Incentive Payment System (MIPS)

- ACI: 21.9 points
- Quality: 43.75 points
- Resource Use: 8 points
- CPIA: 15 points

MIPS Composite Score: **88.65**
Take Home

- 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.
Take Home

• If not using an EHR, start/continue researching options
  • MU will be 25% of your composite score in 2019 (based on 2017)
    • can’t achieve without an EHR
  • PQRS will be 50% of your composite score and claims-based reporting will be retired in future
    • EHR-based processes make PQRS easier
  • Value-based Payment Modifier tied to PQRS and will be 10% of your composite score

• If using an EHR, engage with your vendor about how they can assist your participation in quality reporting programs
RevAspire powered by RevolutionEHR

• RevAspire is a technology-enabled service that supports, equips and assists RevolutionEHR customers through the entire process of CMS quality reporting

• RevAspire frees provider and 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
Thank you!

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