MU, MACRA, MIPS, and MORE

Scott Jens, OD, FAAO
CEO, RevolutionEHR
What is Quality Reporting?

- 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
Physician Compare

Find physicians and other health care professionals
Find group practices
Search another way

Primary specialty: Optometry

Participation in quality activities:
Participation in quality activities is important because it can improve care for people with Medicare. The most recent information on quality activities is from 2014. If this health care professional participated in any quality activities, they are listed below.

- Reported quality measures
- Used electronic health records

View information about quality activity participation.

Gender: Male
Education:
Graduated: 2002
School: PENNSYLVANIA COLLEGE OF OPTOMETRY
BlueCross BlueShield of Alabama
### Doctor Quality of Care Rating

What's Quality of Care? | About the Rating | How do I use this?

Data collection period: Oct 2014 to Sep 2015

**Composite Clinical Star Ratings:**

<table>
<thead>
<tr>
<th>Patients under 65</th>
<th>Patients 65 and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Quality Measures</td>
<td>All Quality Measures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality of Care Measures</th>
<th>Patients Under 65 years</th>
<th>Patients over 65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Preventative/Ambulatory Services - Adults</td>
<td>No Rating Available</td>
<td>Provider Score: 60</td>
</tr>
<tr>
<td>Yearly Monitoring of Drug Therapy for Patients With Heart Conditions (ACE/ARB)</td>
<td>Provider Score: 82</td>
<td>No Rating Available</td>
</tr>
<tr>
<td>Yearly Monitoring of Drug Therapy for Patients With Heart Conditions (Digoxin)</td>
<td>Provider Score: 0</td>
<td>No Rating Available</td>
</tr>
<tr>
<td>Yearly Monitoring of Drug Therapy for Patients With Heart Conditions (Diuretics)</td>
<td>Provider Score: 87</td>
<td>No Rating Available</td>
</tr>
</tbody>
</table>
Federal health officials, insurers agree on how to rate doctors’ quality

By Amy Goldstein  February 16 at 3:43 PM  Follow @goldsteinamy
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
• Professional advocacy
• PQRS satisfaction
• How does MORE relate to Meaningful Use?
  • OD-specific “specialized registry” for the Public Health Reporting objective
• Do I need to register with MORE to meet Meaningful Use?
  • If AOA member, yes. Registration is included in dues.
  • If not AOA member, no. CMS does not expect providers to engage with registries sponsored by specialty societies they are not affiliated with.
• 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 a PQRS Alert link on the Coding screen:
PQRS Overview

• 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
PQRS Overview

- 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)

- In 2013, 26% of those who attempted to participate via claims were unable to submit any measures satisfactorily, compared to only 5% using an EHR.
  - *-2013 Physician Quality Reporting System and eRx Reporting Experience and Trends*
• 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 2% penalty
  • Claims-based reporting is the most challenging method and likely to be retired by CMS in the near future
  • Providers using a 2014 certified EHR should consider electronic reporting
Value-Based Payment Modifier Overview

• 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%)

• All ODs who participate in Fee-For-Service Medicare will be affected by the Value-Based Payment Modifier in 2018 based on 2016 PQRS performance.
Value-Based Payment Modifier Overview

<table>
<thead>
<tr>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Quality</td>
<td>Average Quality</td>
<td>High Quality</td>
</tr>
</tbody>
</table>

- High Cost - Low Quality
- Average Cost - Low Quality
- Low Cost - Low 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>
<td>$700</td>
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<td>$50,000</td>
<td>$1,500</td>
<td>$2,000</td>
<td>$3,500</td>
</tr>
</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 Merit-Based Incentive Payment System (MIPS)

\[
UAF_{2015} = \frac{\text{Target}_{2014} - \text{Actual}_{2014}}{\text{Actual}_{2014}} \times 0.75 + \frac{\text{Target}_{4/96-12/14} - \text{Actual}_{4/96-12/14}}{\text{Actual}_{2014} \times (1 + SGR_{2015})} \times 0.33
\]
Coming Soon:
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

^As of 2021
2019: PQRS 50%, VBM 10%
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

Coming Soon:
The Merit-Based Incentive Payment System (MIPS)
Coming Soon:
The Merit-Based Incentive Payment System (MIPS)
Quality Reporting Take Home

• Satisfactory participation is required to avoid penalties

• 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?
The How

• If not using an electronic health record, start/continue researching options
  • MU will be 25% of your composite score
  • PQRS will be 30% of your composite score and claims-based reporting will be retired in future
  • Value-based Payment Modifier tied to PQRS and will be 30% of your composite score
• If using an electronic health record, engage with your vendor about quality reporting
• 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?

Scott Jens, OD FAAO
CEO, RevolutionEHR
sjens@revolutionehr.com