Worry about it now…
worry about it later…

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Disclaimer:
We are also consultants for Summitec Medical and as such we do acknowledge a financial interest in the subject matter of this presentation.

It’s getting tough to decide what is important right now, and what can wait.

- Every year we have new rules to interpret and apply to our practices.
- Medicare has a vision for patient care that is becoming defined, but it certainly challenging for practices to keep up with.
- It’s especially challenging if you personally do not approve or believe in the direction we are moving in.

First let’s take our personal opinions out of the picture.

- What will penalties to Medicare reimbursements do to your practice?
- Is it greater than the cost of participating in CMS programs?
- It has to be a practice wide decision with buy in. You can’t do everything alone.

Disgust
- Eyebrows pulled down
- Nose wrinkled
- Upper lip pulled up
- Lips loose

Unsuccessful people make decisions based on their current situation; successful people make decisions based on where they want to be.
CMS Programs

- Meaningful Use
- Physician Quality Reporting System (PQRS)
- Value Based Modifier (VBM)
- Measure Based Incentive Program (MIPS)

Meaningful Use

Involves utilizing your CEHRT to collect data on all patients to show you are able to utilize your product in a manner that promotes quality care, patient involvement and continuity across providers.

CMS Programs

Meaningful Use still includes 9 CQM across 3 domains.

Use of High-Risk Medications in the Elderly
Tobacco Screening
Influenza Immunization
Pneumonia Vaccination Status for Older Adults
Diabetic Eye Exam
Diabetes Hemoglobin A1c Poor Control
Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
Diabetic Retinopathy: Documentation
Diabetic Retinopathy: Communication with Physician Managing Ongoing Diabetic Care
HIV/AIDS: Medical Visit
Documentation of Current Medications
Cataract: 20/40 or Better Visual Acuity
Closing the Referral Loop: Receipt of Specialist Report

### Payouts

<table>
<thead>
<tr>
<th>Start Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Maximum Payout</th>
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<tr>
<td>2013</td>
<td>$18,000</td>
<td>$12,000</td>
<td>$7,840</td>
<td>$3,920</td>
<td>$1,960</td>
<td>$0</td>
<td>$43,720</td>
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<td>2012</td>
<td>-------</td>
<td>$18,000</td>
<td>$11,760</td>
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<td>$3,920</td>
<td>$1,960</td>
<td>$43,480</td>
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<td>2013</td>
<td>-------</td>
<td>-------</td>
<td>$14,700</td>
<td>$13,760</td>
<td>$7,840</td>
<td>$3,920</td>
<td>$38,220</td>
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<tr>
<td>2014</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>$13,760</td>
<td>$7,840</td>
<td>$3,920</td>
<td>$23,520</td>
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<tr>
<td>2015 and beyond</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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Meaningful Use Penalties

- "Beginning in 2015, eligible professionals who do not successfully demonstrate meaningful use will be subject to a payment adjustment. The payment reduction starts at 1% and increases each year that an eligible professional does not demonstrate meaningful use, to a maximum of 5%". - CMS
- Penalty is on Medicare part B and Railroad
- Penalty uses the swinging year system- 2015 non reporters see the penalty in 2017
- Penalty follows the provider across practices

Worry about this program NOW...

Physicians Quality Reporting System

- Moving to quality based healthcare makes this program a top priority since it is the basis for much of your results.
- No cash reward…(but VBM, MIPS impact)
- REPORTING OPTIONS:
  - Claims
  - Registry (Individual or Measure Group)
  - E.H.R Registry
  - Qualified Clinical Data Registry
  - GPRO (must register intent for GPRO reporting by 6/30/16)

Physicians Quality Reporting System

- How have you reported your measures?
- How many did you report? (9 across 3 domains or a measure group)
- GPRO or Group Reporting is VERY different than reporting a measures group.
- Cannot see true results until Fall the year after submission. Scrutinize your results.
- Do you have super sub-specialists in your practice?
- Can you make your MU CQM’s match your PQRS measures to minimize workflow- depends on your reporting method.

All Measures are not the same...

<table>
<thead>
<tr>
<th>Measure</th>
<th>Domain</th>
<th>Cross-cast</th>
<th>Claim</th>
<th>GCOR</th>
<th>E.H.R</th>
<th>GPRO</th>
<th>Measure Group</th>
<th>Registry</th>
<th>MU CQM?</th>
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<tbody>
<tr>
<td>Hemoglobin A1C Poor Control</td>
<td>Effective Clinical Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>POAG: Optic Nerve Exam</td>
<td>Effective Clinical Care</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>ARMD: Dilated Macular Exam</td>
<td>Effective Clinical Care</td>
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<td>X</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Diabetic Ret: Documentation</td>
<td>Effective Clinical Care</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Ret: Communication w/PCP</td>
<td>Communication &amp; Care Coord</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
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<tr>
<td>Pneumonia Vaccination &gt;65 years</td>
<td>Community/Population Health</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Y</td>
<td></td>
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</tr>
</tbody>
</table>

Whatever you did in the past, did it work?

Providers at more than 1 practice need to participate at each location. Penalty is assessed for each provider on a………

Penalty: 2016 participation year = 2018 penalty -2.0%

MAV - is you against your peers, if they are all sending 9 measures how can you justify doing 4?

If you find yourself receiving a penalty letter. Look into filing the Informal Review, is/was there a true reason? Don’t assume you will pass just because you filed.

Worry about this program NOW….it’s bigger than just -2.0%

Why you don’t want to try your luck with the MAV process..

“The Value Modifier provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule based upon the quality of care furnished compared to cost during a performance period.”- CMS

2016 results determine 2018 (+/-) modifier.

2016/2018 applies to all providers (MD, DO, OD, PA-C, CRNP, etc)

Applies to Solo practitioners or groups of 2 or more.

Standards for 2018 modifier are not finalized.

“CY 2018 will be the final payment adjustment period under the Value Modifier.”- CMS

PQRS results are CRUCIAL to this program.

2016 Specialty Measure Sets

CMS has been collaborating with specialty societies to ensure that the measures represented within the Specialty Measure Sets accurately reflect the quality actions that may occur within a particular clinical area. The Specialty Measure Sets should be used as a guide for eligible professionals to choose measures applicable to their specialty. The Specialty Measure Sets are NOT required measures but are suggested measures for specific specialties.

The 2016 Specialty Measure Sets are indicated below:

1. 2016 Cardiology Preferred Specialty Measure Set
2. 2016 Dermatology Preferred Specialty Measure Set
3. 2016 Emergency Medicine Preferred Specialty Measure Set
4. 2016 Gastroenterology Preferred Specialty Measure Set
5. 2016 General Preventive Medicine/Primary Care Preferred Specialty Measure Set
6. 2016 General Surgery Preferred Specialty Measure Set
7. 2016 Hospitalist Preferred Specialty Measure Set
8. 2016 Internal Medicine Preferred Specialty Measure Set
9. 2016 Mental Health Preferred Specialty Measure Set
10. 2016 Multiple Chronic Conditions Preferred Specialty Measure Set
11. 2016 Urology/Genitourinary Preferred Specialty Measure Set
12. 2016 Oncology/Hematology Preferred Specialty Measure Set
13. 2016 Ophthalmology Preferred Specialty Measure Set
14. 2016 Pathology Preferred Specialty Measure Set
15. 2016 Physical Therapy/Occupational Therapy/Certified Nephrology Preferred Specialty Measure Set
16. 2016 Radiology Preferred Specialty Measure Set
17. 2016 Hematology/Oncology Preferred Specialty Measure Set

VBM 2015/2017

Solo & 2-9 EP’s… potential +2.0(x) to -2.0%

10 + EP’s… potential +4.0(x) to -4.0%

Mandatory penalty for providers who did not participate in PQRS

Mid Year QRUR available…but do you really want to see half of your results?

Final QRUR reports/results expected October 2016

Cost and Quality

Quality = PQRS data (you are in control of this)

Cost = determined from pt sample, based on their total care …not just the care you gave. (hospitalization) (cannot be controlled by practice)

Used to generalize your entire practice against (peers).
The next thing to worry about…
Proposing change

PQRS, Meaningful Use, and Value Based Modifier programs are proposed to “sunset” at the end of 2018.
That means 2016 is the last year you would participate in these programs (as they exist now).
In 2017 you would begin a new program, the results of which will apply to your 2019 fee schedule.
Proposed changes to the Merit Based Incentive Program System and Alternative payment Models – Comment period now open.
Resources

- CMS Listserv: