Physician Quality Reporting System - Meaningful Use - Value-Based Payment Modifier - Accountable Care Organization - Patient Centered Medical Home - HEDIS - Merit-based Incentive Payment System (MIPS)

ReportingMD®

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In This Issue

Customer Questions

Q: If a provider billed Medicare at multiple practices (different Tax ID Numbers) during the reporting year, does he or she have to report for each one?
A: Yes, PQRS is done at the individual NPI and TIN combination, so a provider who bills Medicare under 2 different TINs must report PQRS for each TIN.

Q: What is a cross-cutting measure?
A: Cross-cutting measures are measures that are reportable by a broad audience of eligible professionals and settings. Many are focused on large-scale public health concerns.

Send us your question(s)
info@ReportingMD.com

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ReportingMD Quarterly Newsletter

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ReportingMD News/Updates

ReportingMD can support you through the transition to the Merit-Based Incentive Payment System (MIPS), which starts in 2017. RMD can submit and report on all submission categories under the MIPS program. Contact us for more information.

Academic Research for Clinical Outcomes (ARCO) in collaboration with ReportingMD has been accepted as a Qualified Clinical Data Registry (QCDR) for the 2016 reporting year. ARCO works collaboratively with various University Health Systems to promote clinically integrated environments and to ensure the utilization of clinical best practices with the goal of improving population health through evidence-based care.

For practices and providers using ReportingMD's Total Outcomes Management (TOM) application, make sure to log in and check your quality performance information throughout the year.

ReportingMD has released Total Outcomes Management V9. Please check with your account manager for your installation date.

Check out the News link on the ReportingMD website for important news and program updates http://reportingmd.com/important-updates/

Contact us if you have any questions.

It's Not Too Late...

... To report for PQRS and avoid the PQRS and Value-Based Payment Modifier (VBM) 4% penalty for the 2016 reporting year.

Contact us to help figure out how.

Did You Know...?

Important Links

Feedback Reports website

CMS PQRS website

Physician Compare website

ReportingMD Brochures

Medical Informatics Calculator (MIC)

Total Outcomes Management (TOM)

Meaningful Use Brochure

New Hampshire Trivia

What is New Hampshire's oldest man-made tourist attraction?
Trivia Answer

Join Our Mailing List!

... Even single provider practices who bill Medicare Part B need to report PQRS to avoid the PQRS and the VBM automatic penalties.

... CMS will be releasing the 2015 PQRS feedback reports in early Fall, which tell you how your providers and/or practices did in their reporting of PQRS data in 2015. The end-year Quality and Resource Use Reports (QRURs), which tell you how your performance was on the measures you reported in 2015 and subsequently your Value-Based Payment Modifier (VBM), will also be released in the Fall of 2016.

The 2017 Proposed Rule, "Medicare Program: Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models", is available for download here: https://www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-and-alternative-payment-model-incentive-under

... you can review your 2015 PQRS Mid-Year Quality and Resource Use Reports (QRURs). The mid-year QRURs are informational only and are not used to calculate your 2015 Value-based Payment Modifier (VBM) cost or quality scores. The Mid-Year QRUR provides interim information about performance on the six cost and three quality outcomes measures that CMS calculates from Medicare claims. These are some of the measures used in the calculation of the Value Modifier. Visit the News/Updates page on the ReportingMD website for more information and for a link to access your mid-year QRURs.

... if you don't report PQRS at all in 2016, you will be subject to the 2% PQRS penalty **AND** either a 2% or 4% Value-Based Payment Modifier (VBM) penalty as well. **Depending on the size of the practice, you could be penalized by up to 6% for not reporting anything for PQRS in 2016.**

Contact us for more information.

2017 Physician Fee Schedule Proposed Rule

Please note that the following information is based on the proposed rulemaking. The information below may or may not go into effect in 2017 depending on what is decided and subsequently released in the final rule.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is aimed at strengthening Medicare access and improving physician payments among other improvements. Out of MACRA is the Quality Payment Program (QPP), which is made up of 2 tracks: The Advanced Alternative Payment Models (APMs) track and the Merit-Based Incentive Payment System (MIPS) track.

The Advanced Alternative Payment Models (APMs) track
CMS encourages many providers and practices to move to Alternative Payment Models like the Medicare Shared Savings Program (MSSP ACO). The MSSP ACO is an example of an Advanced APM and CMS will reward Qualifying Participants (QPs) of Advanced APMs with a 5% lump sum bonus. Additionally, QPs will also avoid the MIPS downward payment adjustment in 2019 based on their participating in an Advanced APM.

The Merit-Based Incentive Payment System (MIPS) track
Under MACRA, many of the pay-for-performance programs that have been active for the last few years have been turned into categories under the MIPS program. There are various measures, activities, and standards for each of those performance categories under MIPS. Below is a list of the 4 MIPS performance categories and the pay-for-performance programs they are replacing, along with general notes about each category:

Quality Performance Category - replaces PQRS - makes up 50% of the MIPS Composite Performance Score (CPS). ReportingMD can report and submit all measures in this category.

Each provider/practice will select 6 measures to report on. 1 of the 6 measures must be a cross-cutting measure and 1 of the 6 measures must be an outcome measure or other high priority measure if no outcome measure is available.

Resource Use Performance Category - replaces cost from the Value-Based Payment Modifier (VBM) - makes up 10% of the MIPS CPS. Submission and reporting not required for this category.
This category will be calculated by CMS and will be based solely on claims. Total per capital cost for all attributed beneficiaries, Medicare spending per beneficiary (MSPB), and several episode-based measures will be used to calculate Resource Use.

Clinical Practice Improvement Activities (CPIA) Performance Category - new (doesn't replace any program) - makes up 15% of the MIPS CPS. ReportingMD can report and submit all activities in this category.
Providers/practices choose activities from the CPIA inventory, which lists over 90 proposed activities.
Full credit for this category for all patient-centered medical homes
A minimum of half credit for Alternative Payment Model (APM) participation

Advancing Care Information (ACI) Performance Category - replaces Meaningful Use - makes up 25% of the MIPS CPS. ReportingMD can report and submit all measures in this category.
Scoring the ACI category will be comprised of a score for participation and reporting, which is the "base score" and a score for performance, called the "performance score".

Click HERE to watch ReportingMD's MIPS webinar covering the proposed rule

Click HERE to read the 2017 Proposed Rule. Contact us for more information.

2016 PQRS Incentive, Payment Adjustment, and Reporting Methods

PQRS and VBM General Notes:

- Group practices of 2+ EPs as well as solo practitioners will be subject to, not only the PQRS penalty, but also to a downward adjustment under the Value Based Payment Modifier (VBM) program for poor performance.
- PQRS penalty ends in 2018 and will be replaced by MIPS, the Merit-Based Incentive Payment System, which will also incorporate PQRS, EHR Meaningful Use, VBM and a new program looking at Clinical Process Improvement and Access.
- Added 3 new Measures Groups options: Cardiovascular Prevention, Diabetic Retinopathy, and Multiple Chronic Condition.
- Under Quality-Tiering for the VBM, TINs that consist of ONLY non-physician EPs will be held harmless from downward adjustments.
- Groups of 10+ EPs would get an automatic -4% downward adjustment in addition to the PQRS -2% automatic penalty for not reporting.
- Groups of 2-9 EPs and solo practitioners would get an automatic -2% downward adjustment in addition to the -2% PQRS automatic penalty for not reporting.

Links to the 2016 CMS Specifications Manuals are below:

- 2016 Individual Measures (IMs) - http://reportingmd.com/wp-content/uploads/2016_PQRS_IM_SpecManual.pdf
- 2016 Measures Groups (MG) - http://reportingmd.com/wp-content/uploads/2016_PQRS_MG_SpecManual.pdf

2016 PQRS Payment Adjustment:

Individual Eligible Professional (EP) Submission:
EPs who do not report PQRS in 2016 will receive a 2.0% downward payment adjustment in 2018 plus the VBM penalty of either 2% or 4% depending on the size of the practice.
Providers will need to do one of the following to satisfactorily report to avoid the penalty for PQRS:

- Report on 1 Measure Group. Must report on 20 unique patients of which at least 11 must be Medicare Part B patients; OR,

- Report on 9 individual Measures that cross 3 NQS domains including at least 1 cross-cutting measure. Must report at least 50% of the eligible events for each of the 9 measures.

  - If less than 9 measures are reportable, the Measure Applicability Validation (MAV) will run.

Group Practice Reporting Option Submission:
Group Practices reporting under the Group Practice Reporting Option (GPRO) who do not report PQRS in 2016 will receive a 2.0% downward payment adjustment in 2018.
GPROs will need to do the following to satisfactorily report to avoid the penalty for PQRS:

- Report on 9 individual Measures across 3 NQS domains including at least 1 cross-cutting measure. Must report at least 50% of the eligible events for each of the 9 measures

  - If less than 9 measures are reportable, the Measure Applicability Validation (MAV) will run.

For Groups of 100+ EPs registered as GPRO for 2016:
GPRO group practices of 100+ eligible professionals must report on 6 individual measures that cross 2 NQS domains as well as the CAHPS for PQRS measures. CAHPS for PQRS is optional for groups of 2-99 EPs. A group must be registered under the Group Practice Reporting Option (GPRO) in order to be eligible to report on the CAHPS for PQRS measures.

GPRO Web Interface is available as a PQRS reporting mechanism for groups with 25 or more providers only.

EHR Incentive Program/Meaningful Use

ONC Certified HIT

Please make sure your Meaningful Use vendor is in compliance with Meaningful Use Stage 2 and is ONC certified. ReportingMD is ONC certified for all measures and can submit your data for both PQRS and MU in one file submission.

ReportingMD's TOM application is ONC certified for submitting your eCQM and PQRS data electronically. This can be accomplished for singular data submission for each program or combined for one submission for both MU and PQRS. This submission would include GPRO clients.

Key facts from the Meaningful Use Final Rule:

EHR Reporting Period

- The EHR reporting period must be completed between January 1 and December 31 of the 2016 calendar year
  - For all returning participants, the EHR reporting period will be a full calendar year from January 1, 2016 through December 31, 2016

- For "new" participants (EPs, eligible hospitals, and CAHs that have not successfully demonstrated meaningful use in a prior year) it will be any continuous 90-day period within the 2016 calendar year

Objectives and Measures

- All providers are required to attest to a single set of objectives and measures. This replaces the core and menu structure of previous stages.
- For MU Stage 2 Program in 2015 through 2017 (including 2016)
  - 10 objectives for Eligible Professionals (EPs), including 2 public health reporting objectives
  - 9 objectives for eligible hospitals and Critical Access Hospitals (CAHs), including 3 public health reporting objectives
  - CQMs reporting for all is same as previously finalized
  - View the 2016 Specification Sheets for Eligible Professionals and Eligible Hospitals and CAHs

- In 2016, all providers must report objectives and measures using EHR technology certified to the 2014 Edition. All providers may report objectives and measures using EHR technology certified to the 2015 Edition, or a combination of the two (if the 2015 Edition is available).

To learn more about the Meaningful Use/EHR Incentive Program, click HERE.

Value Based Payment Modifier (VBM)

For 2016:
In 2016, if a practice does not successfully report PQRS, they will be subject to a PQRS penalty of 2% as well as an automatic Value Based Payment Modifier (VBM) penalty as follows:

- 1-9 Providers - 2%
- 10+ Providers - 4%

Physicians in groups with 2-9 EPs and physician solo practitioners receive upward, downward, or neutral VBM adjustment under quality-tiering.

Physicians in groups with 10+ EPs can receive upward, neutral, or downward VBM adjustment under quality-tiering.

Beginning in CY 2018, the VBM will apply to non-physician EPs in groups with 2+ EPs and to non-physician EPs who are solo practitioners.

Feel free to Contact us for more information about the Value-based Payment Modifier.

Accountable Care Organization (ACO) Reporting -

ACO Reporting Facts:

- If an ACO fails to successfully report on quality measures, all groups and solo practitioners under the ACO will be subject to the automatic downward adjustment

- If the Accountable Care Organization (ACO) fails to effectively "REPORT" on behalf of the participants, then the participants will receive **2% PQRS penalty + 4% VBM penalty (2% for groups under 10)**

- The 2018 VBM for Shared Savings Program Participants will have their VBM calculated as follows for the 2018 VM (2016 performance year):

Cost Composite for the VBM will be set to average
Quality Composite based on the ACOs quality data submitted through the GPRO web-interface and the ACO all-cause hospital readmissions measure, as calculated under the Shared Savings Program

- If the ACO is not successful in satisfactorily reporting quality data as required for the Shared Savings Program, all groups and solo EPs participating in the ACO will be subject to the automatic downward VBM adjustment

Contact us for more information.

How Do I...

... Access my feedback reports for PQRS? You will need to log into the new Enterprise Identify Management (EIDM) portal, which you can access by clicking on "CMS Secure Portal" at the following website: http://portal.cms.gov

If you have trouble logging in using your old IACS account credentials, you will need to contact the CMS QualityNet Help Desk at 1-866-288-8912 or via email at qnetsupport@hcqis.org.

Recent/Upcoming Shows...

ReportingMD was the gold sponsor for the NH MGMA September program meeting on 9/14/16 in Manchester, NH.

ReportingMD recently key sponsored the Ohio Cancer Research 25th Star Award Gala July 14, 2016. See some of the ReportingMD staff who attended this event below.

ReportingMD exhibited at the New England Regional MGMA Conference at the Mount Washington Resort in Bretton Woods, NH May 4-6, 2016.

We hope you found this newsletter informative. Please provide us with any feedback and/or topics you would like addressed in future publications. You can email us at Contact Us

Sincerely,

Michael T. Deyett, MHA
President
ReportingMD, Inc.