Physician Quality Reporting System - Meaningful Use - Value-Based Payment Modifier - Accountable Care Organization - Patient Centered Medical Home

ReportingMD®

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In This Issue

Customer Questions

Q: When does the Merit-Based Incentive Payment System (MIPS) program start?
A: 2017 is the first program year for the MIPS program.

Q: What do I do if I cannot log into the new EIDM system with my old IACS account credentials?
A: You will need to contact the CMS QualityNet Help Desk at either 1-866-288-8912 or qnetsupport@hcqis.org

December 2015

ReportingMD Quarterly Newsletter

Quarter - 4 - 2015

ReportingMD Chosen to Participate in Designing the New Merit-based Incentive Payment System (MIPS) for CMS

12/1/15 - Representatives from ReportingMD were identified as key stakeholders with technical expertise who were invited to the Washington, D.C. area to take part in designing the new Merit-Based Incentive Payment System (MIPS), which will debut starting in 2017. MIPS will combine the current Physician Quality Reporting System (PQRS), Meaningful Use (MU) and Value-Based Payment Modifier (VBM) into one program as required under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Representatives from ReportingMD met on-site with program leaders from the Center for Medicare & Medicaid Services (CMS) and other state agencies, to identify opportunities to streamline and improve the current processes to enable us a smooth transition when MIPS is rolled out. The overall goal was to strive to design MIPS in a way that is responsive to stakeholder needs.

ReportingMD is proud to be invited to participate in this meaningful event. We are also excited to be an advocate for our clients and all impacted stakeholders.

Contact us if you have any questions.

ReportingMD News/Updates

ReportingMD has a new website. Check us out at www.ReportingMD.com!

Contact us if you have any questions.

It's Not Too Late...

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

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

New Hampshire officially became a state on what date?

Trivia Answer

Join Our Mailing List!

... To submit an informal review if you feel that you were incorrectly assessed the 2016 payment adjustment after reviewing your feedback report for the 2014 reporting year. CMS is also sending out letters identifying if a provider or a group practice will be receiving the penalty for not satisfactorily reporting in 2014. Penalties will initiate on 1/1/16. Informal reviews must be submitted between September 9, 2015 and December 16, 2015. All informal review requests must be submitted electronically via the Quality Reporting Communication Support Page (CSP) under the Related Links section of the Physician and Other Health Care Professionals Quality Reporting Portal. That page will only be available between 9/9/15 and 12/16/15.

... To avoid a payment adjustment for not reporting PQRS in 2015. Contact us to help figure out how.

Did You Know...?

... On 11/16/15 - CMS released the PQRS Final Rule entitled "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016". You can access the Final Rule from the Important Updates page on the ReportingMD website here: http://reportingmd.com/important-updates/

... On 10/6/15 - CMS released the Meaningful Use Final Rule. You can access the MU Final Rule from the Important Updates page on the ReportingMD website here: http://reportingmd.com/important-updates/

... If you don't report PQRS at all in 2015, you will be subject to the 2% PQRS penalty AND either a 2% or 4% Value-Based Payment Modifier (VBPM) 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 2015.

... On July 13, 2015, CMS transitioned from the IACS system to the EIDM system and the IACS system was retired. The new Enterprise Identity Management (EIDM) system will be the system used by practices and providers to access multiple CMS applications including their QRURs, PQRS feedback reports as well as the GPRO registration portal among other applications. To access this portal, click on "CMS Secure Portal" at the following website: http://portal.cms.gov.

Contact us for more information.

2016 Physician Fee Schedule Final Rule

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

Items to note:

- Finalized that group practices of 2+ EPs as well as solo practitioners will be subject to, not only, the PQRS penalty but also subject 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.
- Finalized to require CAHPS for PQRS surveys for groups of 25+ EPs that register to report GPRO web interface as their reporting option only.
- Finalized the addition of the following 3 new Measures Groups options: Cardiovascular Prevention, Diabetic Retinopathy, and Multiple Chronic Condition.
- If reporting CQMs electronically, providers must report using the most recent version of the electronic specifications for the CQMs.
- For the 2016 performance year, the Value-Based Payment Modifier (VBM) will apply to physicians, PAs, NPs, CNSs, and CRNAs in groups of 2+ EPs and those who are solo practitioners as identified by their TIN.
- Under Quality-Tiering for the VBM, TINs with physicians, PAs, NPs, CNSs, and CRNAs will be subject to upward, neutral or downward adjustments.
- Under Quality-Tiering for the VBM, TINs that consist of non-physician EPs only will be held harmless from downward adjustments.
- Finalized to keep the VBM adjustment levels for groups of 10+ EPs and for groups of 2-9 EPs who don't report PQRS at all, the same.
- 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.**
- Finalized that for groups of 2-9 EPs and solo practitioners, under quality-tiering they would be subject to a potential upward adjustment up to **+2% or a potential downward adjustment of -2%, which differs from 2015**
- The 2018 VBM for Shared Savings Program Participants will have their VBM calculated as follows for the 2018 VM (2016 performance year):

  Cost composite - set to Average
  Quality composite - based on ACOs quality data submitted through the GPRO web-interface and the ACO all-cause hospital readmissions measure as calculated under the Shared Savings Program

- Finalized that 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.
- Finalized for the VBM for TINs that are participating in the Pioneer ACO model, CPC Initiative, or other Similar Innovation Center Models that (for the 2017 VBM and 2018 VBM) the VBM be waived if at least one EP participated in any of the above or Similar Innovation Center Models during the reporting year

Feel free to Contact us for more information and to help you navigate the changes.

2015 PQRS Incentive, Payment Adjustment, and Reporting Methods

2015 PQRS Payment Adjustment:

Individual Eligible Professional (EP) Submission:
EPs who do not report PQRS in 2015 will receive a 2.0% downward payment adjustment in 2017.
Providers will need to do one of the following to satisfactorily report to avoid the penalty for PQRS in 2015:

- 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 under PQRS in 2015 will receive a 2.0% downward payment adjustment in 2017.
GPROs will need to do the following to satisfactorily report to avoid the penalty for PQRS in 2015:

- 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 GPRO Submissions:
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 (QRDA3 Generator) 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:

- 90 day reporting period, which is now aligned with the calendar year instead of the fiscal year in order to align MU reporting with other CMS reporting programs. This applies for all providers in 2015, for new participants in 2016 and 2017 as well as for any provider moving to MU Stage 3 in 2017
- Stage 3 requirements are optional for all providers in 2017. Those providers choosing to start MU Stage 3 in 2017 will only have a 90 day reporting period. In 2018, however, all participants will be required to comply with MU Stage 3 requirements (using HER technology that is certified to the 2015 edition)

For MU Stage 2 Program in 2015 through 2017

- 10 objectives for Eligible Professionals (EPs), including 1 public health reporting objective
- 9 objectives for eligible hospitals and Critical Access Hospitals (CAHs), including 1 public health reporting objective
- CQMs reporting for all is same as previously finalized

For MU Stage 3 Program in 2017

- 8 objectives for EPs, eligible hospitals and CAHs
- More flexible options for measure selection for the public health reporting element
- CQM reporting is aligned with the CMS quality reporting programs

Recently, CMS answered the following question on their EHR Incentive Program FAQs page:
Question: [Medicare EHR Incentive Program] For the Medicare EHR Incentive Program, can I report a CQM with a zero result in the numerator and/or denominator?
Answer: While we strongly encourage providers to report CQMs which are relevant to their patient population, zero is an acceptable result provided that this value was produced by certified EHR technology.

Click HERE to view this FAQ

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

Value Based Payment Modifier (VBM)

In 2015, if a practice does not successfully report PQRS in 2015, they will be subject to 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 only the upward or neutral VBM adjustment under quality-tiering

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

Value-Based Payment Modifier (VBM) – Quality Tiering Approach for 2017 (based on 2015 reporting year): Groups of 10+ eligible providers:

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

Value-Based Payment Modifier (VBM) – Quality Tiering Approach for 2017 (based on 2015 reporting year): Groups of Solo Practitioners and Groups of 2-9 Eps:

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	+0.0%	+0.0%	+1.0x*
High Cost	+0.0%	+0.0%	+0.0%

Reference: 2015 Updates to the Physician Quality Reporting System (PQRS) & the Value Based Payment Modifier. Philadelphia Regional Office of CMS. 7 April, 2015. Centers for Medicare & Medicaid Services.

In the fall of 2015, Quality and Resource Use Reports (QRURs) were released and include your two composite scores (quality of care; cost of care) based on your group's standardized performance for 2014 reporting year.

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

There are some exceptions for VBM for some specialties.

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

Accountable Care Organization (ACO) Reporting -

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

There are 33 Accountable Care Organization measures across 4 domains

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)

Groups and solo practitioners participating in an ACO under the **Shared Savings Program** in the CY 2015 performance period will have their Value Modifier calculated as follows for the CY 2017 payment adjustment period:

- The Cost Composite for the VBPM will be set to average

- The Quality Composite will be based on the ACO's quality data reported

Physician solo practitioners and physician groups in which at least one eligible professional participates in the **Pioneer ACO Model or CPC Initiative** in 2015 will have their Value Modifier calculated as follows for 2017:

- Cost Composite: Average
- Quality Composite: Average

Solo practitioners and groups in which at least one eligible professional participates in the **Pioneer ACO Model or CPC Initiative** in 2015 will be classified as Category 1 and will not be subject to the VM downward adjustment for CY 2017.

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 that is on the following website 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@hcgis.org

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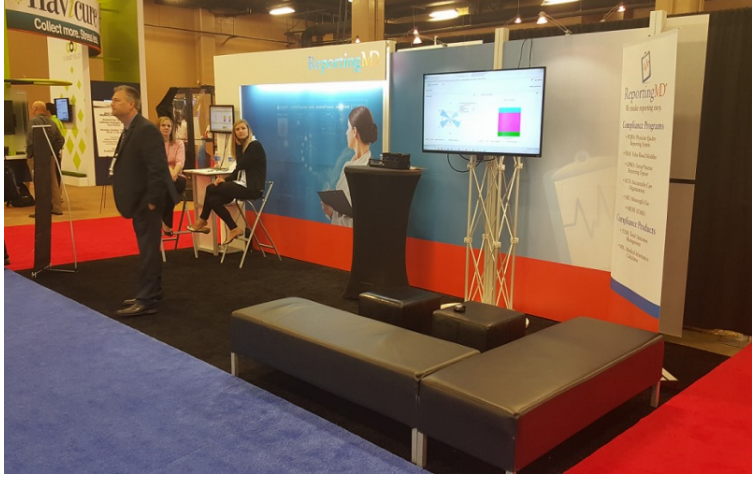
Recent/Upcoming Shows...

ReportingMD exhibited at the 2015 MGMA Annual Conference in Nashville, TN October 11-14, 2015. View our new display below

MGMA®
Medical Group Management Association
AdminiServe® Partner



ReportingMD will be exhibiting at the 2016 American Medical Group Association (AMGA) Annual Conference in Orland, FL March 9-11, 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.