# MIPS:
## Steps to Take in 2016



## We will be covering the following information today……

2016 Programs Impacting 2018 Payments

- MU (Medicare EHR Incentive Program: "Meaningful Use")
- PQRS (Physician Quality Reporting System)
- VBM (Physician Value-based Payment Modifier)

How to obtain your QRUR (Quality and Resource Use Report)

# MU 2016

Medicare EHR Incentive Program: Meaningful Use

For additional information go to

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2016ProgramRequirements.html

- Prep for EHR
- Alternative Exclusions for 2016
- Public Health Reporting
- Health Information Exchange
- Patient Electronic Access
- Security Risk Analysis
- 2016 Objective Measures



# MU 2016 - Who is Eligible

MEDICARE:

- Doctor of medicine or osteopathy
- Doctor of dental surgery or dental medicine
- Doctor of podiatry
- Doctor of optometry
- Chiropractor

MEDICAID:

- Doctor of medicine or osteopathy
- Nurse practitioner
- Certified nurse-midwife
- Dentist
- Physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic

# MU 2016 - Medicaid Eligible Criteria



EP must meet ONE of the following criteria:

- Have a minimum 30% Medicaid patient volume*
- Have a minimum 20% Medicaid patient volume, and is a pediatrician*
- Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals

* Children's Health Insurance Program (CHIP) patients do not count toward the Medicaid patient volume criteria.

# MU 2016 - Medicaid



- Contact your local state health department for the details pertaining to the Medicaid requirements for Meaningful Use, as it varies from state to state

- Medicaid MU program will continue beyond 2016

Medicare MU will sunset at the end of 2016.

Aspects of the program will fall under the

"Advancing Care Information" performance category of MIPS (Merit-based Incentive Payment System)

starting January 1, 2017.

# MU 2016 – 10 Objectives



1. Protect Patient Health Information – YES/NO
2. Clinical Decision Support - YES/NO/Exclusion
3. *Computerized Provider Order Entry (CPOE) – Numerator/Denominator/Exclusion
4. Electronic Prescribing (eRx) – Numerator/Denominator/Exclusion
5. Health Information Exchange – Numerator/Denominator/Exclusion
6. Patient Specific Education – Numerator/Denominator/Exclusion
7. Medication Reconciliation – Numerator/Denominator/Exclusion
8. Patient Electronic Access (VDT) – Numerator/denominator/Exclusion
9. Secure Messaging - YES/NO/Exclusion
10. Public Health Reporting – YES/NO/Exclusion

* There is an alternative exclusion for Stage 1 providers for objective #3.

# MU 2016 – Objectives



1. **Protect Patient Health Information** - Conduct and review security risk analysis

2. **Clinical Decision Support** – EP must satisfy both measures:

   **Measure 1**: Implement five clinical decision support rules related to four or more clinical quality measures or are clinically relevant to the scope of your practice.

   **Measure 2**: The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.

   EXCLUSION (Measure 2): Any EP who writes fewer than 100 medication orders during the EHR reporting period.

# MU 2016 – Objectives continued



3. **Computerized Provider Order entry (CPOE) –** Must satisfy all three unless exclusion applies:

   **Measure 1**: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

   **Measure 2**: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

   **Measure 3**: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerize provider order entry.

   STAGE 1: Can take the exclusion for measure 2 & 3

   EXCLUSION: Any EP who writes fewer than 100 medication orders, 100 lab orders or 100 radiology orders during the EHR reporting period

# MU 2016 – Objectives continued



4. **Electronic Prescribing (eRx)** - More than 50 percent of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

   EXCLUSION: Writes fewer than 100 permissible prescriptions during the EHR reporting period;

   or

   Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.

# MU 2016 – Objectives continued



5. **Health Information Exchange** - The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.

EXCLUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

*Setting of Care defined as: Hospital, primary care practice, specialty care practice, long-term care, home health, rehabilitation facility

*Summary of Care: Must contain at least three fields noted as required (current problem list, current medication list, and current allergy list)

# MU 2016 – Objectives continued



6. **Patient Specific Education -** Patient specific education resources identified by CEHRT are provided to patients for more than 10 percent of all "unique patients" with office visits seen by the EP during the EHR reporting period.

EXCLUSION: Any EP who has no office visits during the EHR reporting period.

"Unique Patient" – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement, that patient is only counted once in the denominator for the measure.

# MU 2016 – Objectives continued



**7. Medication Reconciliation -** The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

EXCLUSION: Any EP who was not the recipient of any transitions of care during the EHR reporting period.

Medication Reconciliation – The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.

# MU 2016 – Objectives continued



**8. Patient Electronic Access (VDT**) – Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

**EPs must satisfy both measures in order to meet this objective:**

**Measure 1**: More than 50 percent of all "unique patients" seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.

**Measure 2**: For an EHR reporting period in 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period.

# MU 2016 – Objectives continued



8. Patient Electronic Access (VDT)

EXCLUSION:

**Measure 1**: Any EP who: Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information."

**Measure 2**: Any EP who: Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information;" or

Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

# MU 2016 – Objectives continued



9. **Secure Messaging** - For an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

EXCLUSION: Any EP who has no office visits during the EHR reporting period; or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

# MU 2016 – Objectives continued



**10. Public Health Reporting –**

**You must meet 2 of the measures unless the exclusion apply.**

**Measure Option 1** – Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data.

**Measure Option 2** – Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data.

**Measure Option 3** – Specialized Registry Reporting: The EP is in active engagement to submit data to a specialized.

(You must register with the public health agency no later than 60 days from the 1st day of your reporting period to be in compliance for this measure)

# MU 2016 – Objectives continued



10. Public Health Reporting

**EXCLUSIONS:**

**Measure 1:** You only need to meet one option to be excluded from the measure

Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period;

Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or

Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period.

**Measure 2:** You only need to meet one option to be excluded from the measure

Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;

Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or

Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.

**Measure 3** : You only need to meet one option to be excluded from the measure

Does not diagnose or treat any disease or condition associated with, or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period;

Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period;

Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

# MU 2016 – Clinical Quality Measures



- You must select 9 measures that cover at least 3 of the 6 domains

  DOMAINS:

  Patient and Family Engagement

  Patient Safety

  Population/Public Health

  Efficient Use of Healthcare Resources

  Clinical Process/Effectiveness

  Care Coordination

- There are no threshold for CQMs so you can report "0" on these measures.

# MU 2016 – Reporting Period



**MEDICARE:**

- The EHR reporting period for all providers is based on a calendar year
- In 2016, the reporting period is as follows:
  - Returning participants: full calendar year
  - First-time participants: minimum of 90 continuous days

**MEDICAID:**

- Varies from state to state
- Visit your local state health department for details on reporting

# MU 2016 – Attestation Deadline



- Returning participants who successfully demonstrate Meaningful Use for CY 2016 and satisfy all other program requirements will avoid the payment adjustment in CY 2018 if the EP successfully attests by February 28, 2017.
- New participants who successfully demonstrate Meaningful Use for 2016 and satisfy all other program requirements will avoid the payment adjustment in CY 2017 and CY 2018 if the EP successfully attests by October 1, 2016, and will avoid the payment adjustment in CY 2018 if the EP successfully attests by February 28, 2017.

# PQRS 2016

Physician Quality Reporting System



PQRS will sunset at the end of 2016.

Aspect of this program will fall under the "Quality" performance category of MIPS (Merit-based Incentive Payment System) starting

January 1st 2017.

# PQRS 2016



This is a quality reporting program that encourages individual eligible professional and group practices to report information on the quality of care

# PQRS 2016 – Who is Eligible



- MD, DO, Doctor of Podiatric Medicine, Optometrist, Dentist, Dental Surgeons, Chiropractors
- Therapist: Physical, Occupational, Speech-Language
- PA, NP, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Anesthesiologist Assistant, Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologist, Advanced Practice Registered Nurse

# PQRS 2016 – Individual Measures



If you have been reporting on individual measures via claims, you must report on 9 measures that cover at least 3 of the 6 Domains. One must be a cross-cutting measure.

**DOMAINS:**

- Patient and Family Engagement
- Patient Safety
- Population/Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/Effectiveness
- Care Coordination

# PQRS 2016 – Measure Groups



- You only need to select **ONE** measure group to report on
- You will report on 20 patients that fall into the requirements for that measure group
- Measure groups MUST be reported through a certified registry

| Samples of Measure Groups: | Measures within Diabetes Measure Group: |
|---|---|
| Asthma | Hemoglobin A1c Poor Control |
| Coronary Artery Disease | Preventive Care and Screening: Influenza Immunization |
| Chronic Kidney Disease | Eye Exam |
| Chronic COPD | Medical Attention for Nephropathy |
| Diabetes | DM Foot and Ankle Care, Peripheral Neuropathy, and |
| Preventative Care | Neurological Evaluation |
| DM Retinopathy | Tobacco Use: Screening and Cessation Intervention |

# VBM

Value-based Modifier Program



VBM will sunset at the end of 2016.

Aspect of this program will fall under the "Resource Use" performance category of MIPS (Merit-based Incentive Payment System) starting January 1, 2017.

# VBM – What is it?



The Value-Based Payment Modifier Program adjusts Medicare Physician Fee Schedule (PFS) payments to a physician or group of physicians (as identified by their Taxpayer Identification Number [TIN]), based on the quality and cost of care furnished to their Medicare Fee-for-Service (FFS) beneficiaries

# VBM – Key Points



- If you are not reporting PQRS measures you will automatically receive negative payment adjustments under VBM
- There is upward payment adjustments
- Eligible Providers under VBM are the same as PQRS
- VBM is calculated on your quality reporting (PQRS) and cost/resource use
- Cost/resource use is based on the claims you submit

# QRUR

Quality and Resource Use Report

# QRUR – What is it?



Quality and Resource Use Reports contain information about physicians performance on the quality and cost of care delivered to Medicare Fee-for-Service patients

# QRUR – 1st Step EIDM!

(Enterprise Identity Data Management)



- You must obtain an EIDM account in order to access your QRUR
- Before requesting, you will first need to determine which one of the following four user roles you want to request:

  GROUP PRACTICE:
  - Security Official role
  - Group Representative' role

  INDIVIDUAL PRACTICE:
  - Individual Practitioner role
  - Individual Practitioner Representative role

# QRUR – EIDM



Make sure you gather all required information before you begin the process

You have 25 minutes to complete each screen (unless a different time is noted on the screen).

Otherwise, you will lose all of the information you entered and will need to start the process again.

# 2018 Payment Adjustments



**Meaningful Use**

- The 1st negative payment adjustment began in 2015 by -1% and has increased each year by 1%.
  - Meaning if you never participated in Meaningful Use you are looking at a -4% payment adjustment in 2018.

**PQRS**

- The first payment adjustment began in 2015 at -1.5% and increased to -2% for 2016 – 2018

**VBM** (Will depend on your practice size)

- In 2018, your negative payment adjustment for an individual provider or group of 2-9 providers will be -2%
- Groups of 10 or more providers will receive -4%

# Need Help? – Who to Call



**Meaningful Use**

EHR Incentive Program Information Center - 888-734-6433

**PQRS (Setting up EIDM account)**

Quality Net Help Desk – 866-288-8912

Email: qnetsupport@hcqis.org

**VBM/QRUR**

Physician Value Help Desk – 888-734-6433, press option 3

Email: pvhelpdesk@cms.hhs.gov

# Resources



**Visit www.sticomputer.com/mips for links to supporting documentation:**

- Medicare EHR Incentive Program (Meaningful Use)
- Physician Quality Reporting System (PQRS) Main Website
- PQRS Cross-Cutting Measures
- PQRS Certified Registries
- VBM Main Page
- How to Obtain an EIDM Account