

A REVIEW OF MIPS, PQRS, VALUE BASED MODIFIERS, AND MU FOR 2017 AND BEYOND

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AOA THIRD PARTY CENTER CODING EXPERTS



Rebecca Wartman OD



Douglas Morrow OD



Harvey Richman OD

WHAT WE WILL COVER

- BRIEF OVERVIEW
- THE ECONOMIC VALUE OF HEALTH AND HEALTHCARE-VALUES, PERCEPTIONS AND ATTITUDES
- CURRENT PQRS PROGRAM VS MIPS BEYOND 2016
- SUCCESS AND PENALTIES
- CURRENT EHR & CQM 2015-16 VS MIPS
 - NEW GUIDANCE RELEASED OCT 1, 2015 SUCCESS AND PENALTIES
- CURRENT VALUE BASED MODIFIERS VS MIPS
- SUCCESSES AND PENALTIES
- OTHER RELATED INFORMATION
- RESOURCES

THE EMERGING VALUE CONTEXT

- RISING COSTS
- RISING COST SHIFTING TO CONSUMERS
- EVIDENCE THAT INNOVATION MAKES A DIFFERENCE
- POTENTIAL PARADIGM EMERGING
 - HIGH COST, HIGH EFFICACY, HIGH CUSTOMIZATION BUT UNAFFORDABLE
- THE QUEST FOR VALUE
 - IOM: BALANCING COST, QUALITY, ACCESS AND EQUITY
 - EVIDENCE BASED MEDICINE AND EVIDENCE BASED BENEFIT DESIGN
 - PAY FOR PERFORMANCE
 - VALUE PURCHASING

ATTITUDES TOWARD VALUE

- STRONG ARGUMENT → AMERICAN HEALTHCARE IS POOR VALUE
- AMERICANS LOVE HIGH TECHNOLOGY MEDICINE AND THINK, AS A SOCIETY, SHOULD SPEND MORE ON IT.....BUT, OPM (OTHER PEOPLE'S MONEY)
- VALUE IN THE EYE OF THE BEHOLDERAND THE PAYER
- VALUE BEING REDEFINED AS WE MOVE TO ENGAGE CONSUMER AS PAYER AND DECISION-MAKER

But HOW do consumers value anything?

Doctors

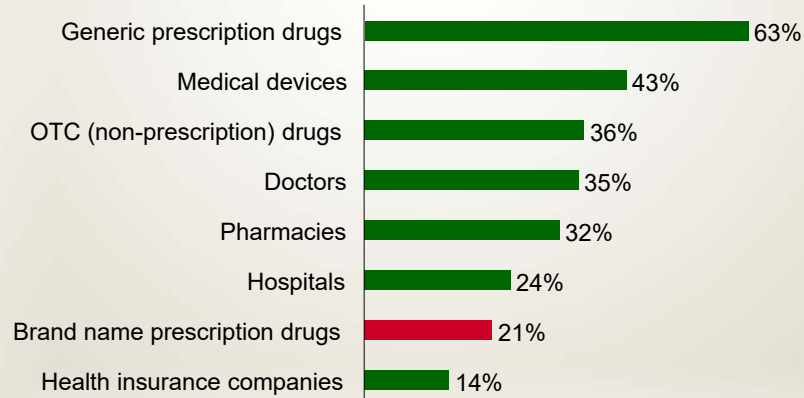
Firefighters

Lawyers



THE VALUE OF HEALTH CARE

Percentage of consumers rating each of the following a very good or fairly good value



Source: Harris Interactive/Wall Street Journal. Aug 19, 2003

CURRENT FEE-FOR-SERVICE MODEL

- MORE WORK WITH LITTLE RETURN
- PAY FOR REPORTING
- MORE COST TO PROVIDER
- LESS TIME WITH PATIENTS MORE PAPERWORK
- TECHNOLOGY IS EXPENSIVE
 - EMR
 - LATEST SCANNING LASER
 - VEP/ERG
 - B SCAN
 - RETINAL IMAGING ETC ETC ETC

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value**.

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians

IF



Overall
physician
costs

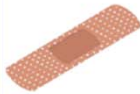
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Target
Medicare
expenditures



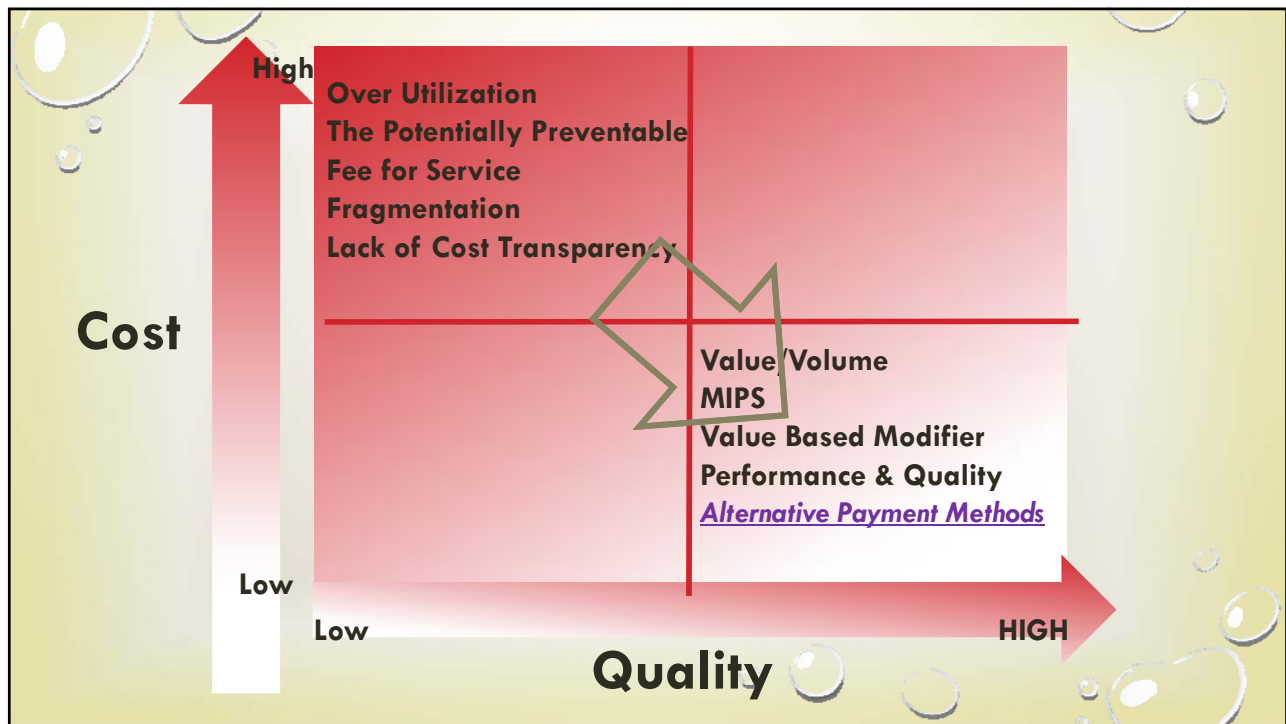
Physician payments
cut across the board



Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

WHERE HAVE WE ALREADY BEEN

- CASH UP FRONT AND LITTLE INSURANCE
- FEE FOR SERVICE AND USUAL AND CUSTOMARY PAYMENT
 - HIGHER YOUR FEES THE MORE YOU GOT PAID
- FEE FOR SERVICE AND SET FEE SCHEDULES
- CARVE OUT PLANS FOR VISION
- HEALTH MAINTENANCE ORGANIZATIONS
- GATEKEEPER SYSTEMS
- MEDICAL HOMES
- ACCOUNTABLE CARE ORGANIZATIONS



BARRIERS TO VALUE-BASED COMPETITION PROVIDERS

• EXTERNAL

- HEALTH PLAN PRACTICES
- SUPPLIER MINDSETS
- MEDICARE PRACTICES
- REGULATIONS
- LACK OF RELEVANT INFORMATION

• INTERNAL

- ASSUMPTIONS, MINDSETS, AND ATTITUDES
- GOVERNANCE STRUCTURES
- MANAGEMENT EXPERTISE
- MEDICAL EDUCATION
- STRUCTURE OF PHYSICIAN PRACTICE
- LACK OF RELEVANT INFORMATION

THE MAKINGS OF AN EVIDENCED BASED CLINICAL OPTOMETRIC GUIDELINE



GUIDELINE DEVELOPMENT: BACKGROUND

- **BUT NOW EVIDENCE BASED APPROACH**
- WHY EVIDENCE BASED?
 - NEED FOR A PRACTICAL AND USEABLE TOOL THAT:
 - OFFERS SUPPORT FOR CLINICAL DECISION MAKING
 - BEST CARE FOR PATIENT
 - POTENTIAL RESEARCH OPPORTUNITIES

Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**



The Merit-based
Incentive
Payment System
(MIPS)

or

Advanced
Alternative
Payment Models
(APMs)

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

PROPOSED MIPS

- ✓ **MIPS is a new program**
 - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
 - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**



Quality

PQRS



Resource use

Value Based Modifier



Clinical practice
improvement
activities

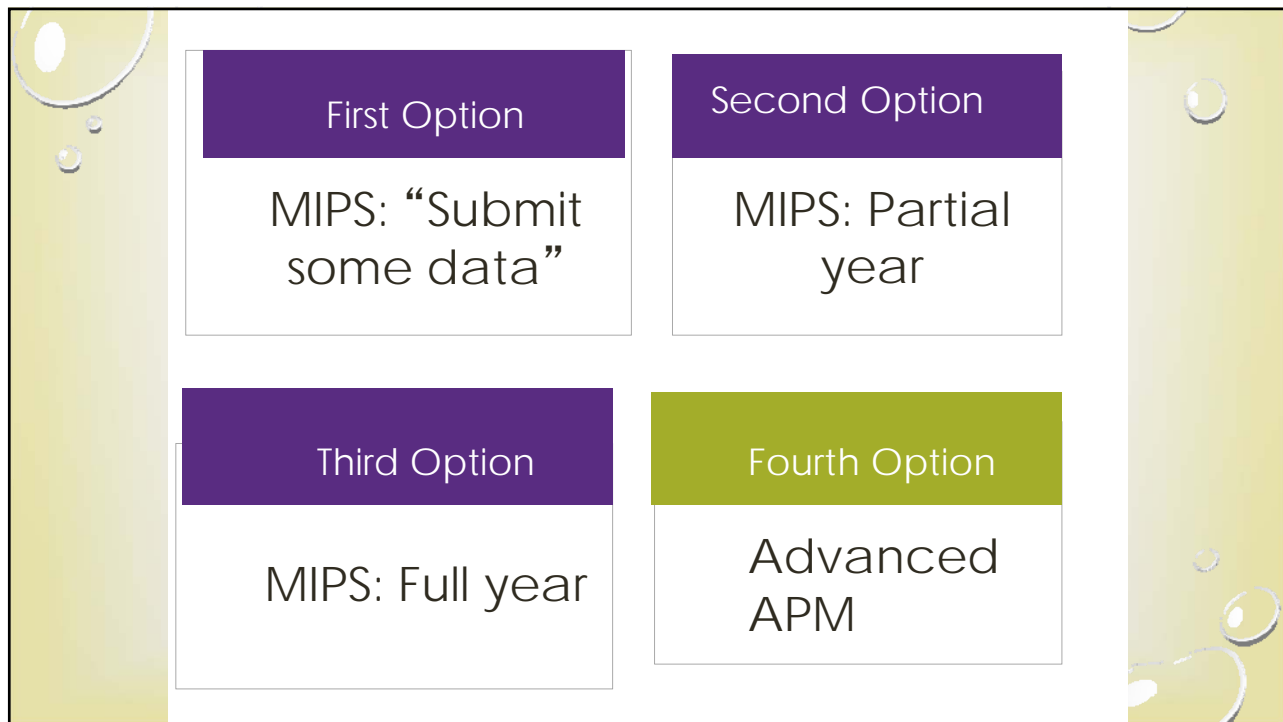
New



Advancing care
information

EHR Incentive

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**



REPORTING OPTIONS

- **FIRST OPTION –**
 - **REPORT SOME DATA**
 - ONE MEASURE IN THE QUALITY PERFORMANCE CATEGORY
 - ONE ACTIVITY IN THE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY
 - AVOID NEGATIVE MIPS PAYMENT ADJUSTMENT

OR

- CHOOSE TO NOT REPORT EVEN ONE MEASURE OR ACTIVITY AND **RECEIVE FULL NEGATIVE 4% ADJUSTMENT**

REPORTING OPTIONS

- SECOND OPTION

- REPORT MIPS FOR < FULL 2017 PERFORMANCE PERIOD BUT \geq 90DAY PERIOD
 - REPORT > 1 QUALITY MEASURE
- OR
- REPORT > 1 IMPROVEMENT ACTIVITY
- OR
- REPORT > REQUIRED MEASURES IN ADVANCING CARE INFORMATION PERFORMANCE CATEGORY

WILL AVOID NEGATIVE ADJUSTMENT AND MAY RECEIVE MODEST BONUS

REPORTING OPTIONS

- THIRD OPTION -

- REPORT FULL 90-DAY PERIOD, BUT IDEALLY, FULL YEAR TO MAXIMIZE CHANCES TO QUALIFY FOR A POSITIVE ADJUSTMENT
- IF EXCEPTIONAL ARE ELIGIBLE FOR AN ADDITIONAL POSITIVE ADJUSTMENT THE FULL YEAR PROVIDES FOR THE "MODERATE" POSITIVE PAYMENT ADJUSTMENT

AN INCENTIVE TO PARTICIPATE FULLY DURING TRANSITION YEAR:
PARTICIPANTS WHO ACHIEVE FINAL SCORE OF 70 OR HIGHER WILL BE ELIGIBLE FOR THE EXCEPTIONAL PERFORMANCE ADJUSTMENT

(FUNDED FROM A POOL OF \$500 MILLION)

REPORTING OPTIONS

- **FOURTH OPTION**
 - PARTICIPATE IN ADVANCED APMS WILL QUALIFY FOR A 5 PERCENT BONUS INCENTIVE PAYMENT IN 2019
- NOT REALLY VIABLE OPTION FOR MOST OPTOMETRIST

FINAL RULING SURPRISES

- **SURPRISE 1:**
 - ADJUSTMENT TO THE LOW-VOLUME THRESHOLD**
 - IF BILL < \$30,000 IN MEDICARE PART B ALLOWED CHARGES OR SEE < 100 MEDICARE PATIENTS PER YEAR, YOU ARE EXEMPT AND CANNOT RECEIVE BONUS BUT NO PENALTY
- **SURPRISE 2:**
 - RESOURCE USE – COST – NOT CONSIDERED THIS YEAR**
 - CMS WILL COLLECT DATA ABOUT COSTS, BUT ONLY BEHIND THE SCENES. RESOURCE USE WILL NOT COUNT FOR 2017

FINAL RULING SURPRISES

- **SURPRISE 3:**

- CLINICAL PRACTICE IMPROVEMENT ACTIVITIES LOWERED**

- IF YOU ARE “SMALL PRACTICE” (<15 DOCS) REPORT 1 “HIGH” WEIGHTED OR 2 MEDIUM WEIGHTED CPIA

- IF YOU ARE A “LARGE PRACTICE” (>15 DOCS) REPORT 2 HIGH WEIGHTED, OR 1 HIGH AND 1 MEDIUM WEIGHTED OR 4 MEDIUM WEIGHTED CPIA

- **SURPRISE 4:**

- ADVANCING CARE INFORMATION (ACI) REQUIREMENTS REDUCED**

- ACI – “MEANINGFUL USE” – DROPPED REQUIREMENT FROM 11 TO 5 BUT MUST REPORT ON ALL REQUIREMENTS IF YOU WANT TO ACHIEVE A SCORE OF 100%.

THREE GROUPS NOT SUBJECT TO MIPS Exclusions

Can report voluntarily but won't receive any money

Newly enrolled Medicare clinicians

Has not submitted claims under any group prior to performance period

Low threshold

<\$30k in Medicare billing
AND
<100 Part B patients

APM participants

Qualifying participants (QPs)
Partial qualifying participants who opt not to report MIPS

NOTE: MIPS does not apply to hospitals or facilities

LOW VOLUME EXCLUSIONS

- \$30, 000 OR FEWER THAN 100 MEDICARE PATIENTS
- TWO EVALUATION PERIODS TO DETERMINE IF YOU MEET LOW VOLUME EXCLUSION:
 - SEPTEMBER 1, 2015 TO AUGUST 31, 2016
 - SEPTEMBER 1, 2016 TO AUGUST 31, 2017
- CMS ESTIMATES THAT 67% OF OD'S MAY BE EXEMPT
- NPI LOOK-UP:
 - THERE WILL BE A MECHANISM TO SEE IF AN GIVEN NPI IS EXEMPT

When does the Quality Payment Program start?



If you're ready, you can begin January 1, 2017 and start collecting your performance data. If you're not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you'll need to send in your performance data by March 31, 2018.

The first payment adjustments based on performance go into effect on January 1, 2019.

2018: **90%**
of Medicare
payments tied
to quality.

2020: **75%** of
commercial
plans will be
value-based.



Jan 2015. <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>

PHYSICIAN QUALITY REPORTING SYSTEM

- PQRI/PQRS BEGAN 2007 - PAY FOR REPORTING PAYING 2% BONUS
- NOW PARTICIPATE TO AVOID 2% REDUCTION IN 2018
- CAN BE SUCCESSFUL FOR 2016 CHOICE OF REPORTING METHODS
- STAND ALONE PQRS PENALTIES ENDING IN 2018
- MERIT BASED INCENTIVE PAYMENT SYSTEM (MIPS) BEGINS IN 2017, PENALTIES BEGIN IN 2019.
- MIPS INCORPORATING MOST OF PQRS REQUIREMENTS



QUALITY REPORTING OPTIONS

- 1. CLAIMS BASED REPORTING – TOO LATE FOR 2016**
- 2. QUALIFIED CLINICAL DATA REGISTRY (QCDR) REPORTING**
AOA MORE REGISTRY – DEPENDING ON YOUR VENDOR'S STATUS
- 3. CERTIFIED ELECTRONIC HEALTH RECORDS REPORTING (CEHRT)**
 - a) DIRECT PRODUCT SUBMISSION
 - b) DATA SUBMISSION

QUALITY REPORTING OPTIONS

4. QUALIFIED REGISTRY

5. GROUP PRACTICE REPORTING

- a) WEB INTERFACE (25+ EPS IN GROUP)
- b) GROUP REGISTRY REPORTING (2+ EPS)
- c) CMS-CERTIFIED SURVEY VENDOR REPORTING (2+ EPS)
- d) EHR – DIRECT OR DATA SUBMISSION (2+ EPS)

2017 QUALITY EYE CARE MEASURES

- **MEASURE 12** –PRIMARY OPEN ANGLE GLAUCOMA (POAG): OPTIC NERVE EVALUATION – CLAIMS, REGISTRY, EHR
- **MEASURE 14** – AGE-RELATED MACULAR DEGENERATION (AMD): DILATED MACULAR EXAMINATION – CLAIMS, REGISTRY
- **MEASURE 19** – DIABETIC RETINOPATHY: COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING DIABETES CARE - CLAIMS, REGISTRY, EHR
- **MEASURE 117** – DIABETES MELLITUS: DILATED EYE EXAM IN DIABETIC PATIENT – CLAIMS, REGISTRY, EHR, WEB INTERFACE
- **MEASURE 140** – AGE-RELATED MACULAR DEGENERATION (AMD): COUNSELING ON ANTIOXIDANT SUPPLEMENT – CLAIMS, REGISTRY
- **MEASURE 141** – PRIMARY OPEN-ANGLE GLAUCOMA (POAG): REDUCTION OF INTRAOCULAR PRESSURE (IOP) BY 15% OR DOCUMENTATION OF A PLAN OF CARE – CLAIMS, REGISTRY (OUTCOME MEASURE BUT NOT FOR AOA MORE)

2017 QUALITY EYE CARE MEASURES

- **MEASURE 18** – DIABETIC RETINOPATHY: DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY **
EHR REPORTING ONLY STILL
- 8 OTHER EYECARE MEASURES FOR REGISTRY, EHR CODES BUT SURGEONS ONLY
 - 6 FOR CATARACT & 2 FOR RETINA
- DO NOT ALLOW USE OF -55 MODIFIER AS FAR AS WE KNOW

2017 QUALITY EYE CARE MEASURES

5 MEASURES THAT ALLOW USE WITH 92000/99000 CODES

- **MEASURE 130** DOCUMENTATION OF CURRENT MEDICATIONS IN THE MEDICAL RECORD – CLAIMS, REGISTRY, EHR
- **MEASURE 131** PAIN ASSESSMENT AND FOLLOW UP – CLAIMS, REGISTRY
- **MEASURE 226** PREVENTIVE CARE AND SCREENING: TOBACCO USE: SCREENING AND CESSATION INTERVENTION – CLAIMS, REGISTRY, EHR, WEB INTERFACE
- **MEASURE 317** PREVENTIVE CARE AND SCREENING: SCREENING FOR HIGH BLOOD PRESSURE AND FOLLOW-UP DOCUMENTED – CLAIMS, REGISTRY, EHR
- **MEASURE 374** CLOSING THE REFERRAL LOOP: RECEIPT OF SPECIALIST REPORT - EHR

REPORT AS DIAGNOSIS INDICATES OR ON EVERY CLAIM WHEN NOT LINKED TO DIAGNOSIS

2017 QUALITY EYE CARE MEASURES

OTHER POSSIBILITIES BUT NOT ALLOWED WITH 92000 ? ?

FINAL, FINAL RULES NOT YET OUT

- **MEASURE 110** PREVENTIVE CARE AND SCREENING: INFLUENZA IMMUNIZATION – CLAIMS, REGISTRY, EHR, WEB INTERFACE
- **MEASURE 111** PNEUMONIA VACCINATION STATUS FOR OLDER ADULTS – CLAIMS, REGISTRY, WEB INTERFACE
- **MEASURE 128** PREVENTIVE CARE AND SCREENING: BODY MASS INDEX (BMI) SCREENING & FU – CLAIMS, REGISTRY, EHR, WEB INTERFACE
- **MEASURE 173** PREVENTIVE CARE AND SCREENING: UNHEALTHY ALCOHOL USE – SCREENING – REGISTRY **MEASURE BACK FOR 2017**
- **MEASURES 236** CONTROLLING HIGH BLOOD PRESSURE – CLAIMS, REGISTRY, EHR, WEB INTERFACE (OUTCOME MEASURE – AOA MORE)

2017 MIPS QUALITY PERFORMANCE CATEGORY

- SELF REPORTED
- SIX (6) MEASURES INCLUDING **1 OUTCOME MEASURE**
 - ANOTHER HIGH PRIORITY MEASURE SHOULD BE REPORTED IF OUTCOME MEASURE IS UNAVAILABLE (BUT WE HAVE OUTCOME MEASURE(S) TO REPORT
 - NO DOMAIN REQUIREMENTS
 - POPULATION MEASURES AUTOMATICALLY CALCULATED
- WILL COUNT 60% IN 2017 REPORTING
- WILL COUNT 50% IN 2019 REPORTING



MEANINGFUL USE

Dr. Jones successfully updates his
Facebook status on rounds

MEANINGFUL USE 2016

- ALL PROVIDERS AFTER 1ST YEAR OF MU **MUST** ELECTRONICALLY REPORT CQM DATA
- **REPORTING PERIOD =12 MONTHS 2016 AND BEYOND...BUT NOT –NOW 90 DAYS**
- AFTER 2016: CANNOT BEGIN TO QUALIFY FOR INCENTIVE PAYMENTS UNDER MEDICAID PROGRAM BUT INCENTIVES WILL BE PAID THROUGH 2021
- MUST CONTINUE TO DEMONSTRATE MU YEARLY TO AVOID PAYMENT ADJUSTMENTS IN FUTURE
- IF YOU SKIP OR FAIL IN ANY ONE YEAR, YOU CAN BEGIN REPORTING AGAIN
- PENALTIES INCREASE EACH YEAR PROVIDER DOES NOT DEMONSTRATE
 - MAXIMUM OF 5% OF MEDICARE PAYMENTS
- **HARDSHIP EXEMPTION DO EXIST**

MEANINGFUL USE MODIFIED STAGE 2 NEW REQUIREMENTS

- MUST ACHIEVE MEANINGFUL USE UNDER **MODIFIED STAGE 2 RULES**
- REQUIRED TO ATTEST TO SINGLE SET OF OBJECTIVES AND MEASURES
- NO LONGER “CORE” AND “MENU” OBJECTIVES
- NOW 10 OBJECTIVES, INCLUDING ONE CONSOLIDATED PH REPORTING OBJECTIVE
- SIGNIFICANT CHANGES TO
 1. PATIENT ELECTRONIC ACCESS, MEASURE
 2. SECURE ELECTRONIC MESSAGING
 3. PUBLIC HEALTH REPORTING
- ALL MEDICARE PHYSICIANS MUST ATTEST BY FEBRUARY 28, 2017

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 1: PROTECT PATIENT HEALTH INFORMATION

- CONDUCT/REVIEW SECURITY RISK ANALYSIS IN ACCORDANCE WITH REQUIREMENTS
- IMPLEMENT SECURITY UPDATES AS NEEDED
- CORRECT IDENTIFIED SECURITY DEFICIENCIES FOR RISK MANAGEMENT PROCESS
- NO EXCLUSIONS OR EXCEPTIONS

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 2: CLINICAL DECISION SUPPORT (BOTH MEASURES)

MEASURE 1

- IMPLEMENT **5 CLINICAL DECISION SUPPORT INTERVENTIONS** RELATED TO 4 + CQM ENTIRE EHR REPORTING PERIOD (IF 4 CQM NOT APPLICABLE →MUST BE RELATED TO HIGH PRIORITY HEALTH CONDITIONS)

MEASURE 2

- ENABLE/IMPLEMENT FUNCTIONALITY FOR DRUG-DRUG &DRUG-ALLERGY CHECKS FOR EHR REPORTING PERIOD (EXCLUSION IF WRITE FEWER THAN 100 MEDICATIONS ORDERS FOR EHR REPORTING PERIOD)

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 3: COMPUTERIZED PROVIDER ORDER ENTRY (SATISFY 3 MEASURES)

MEASURE 1:

>60% MEDICATION ORDERS RECORDED USING COMPUTERIZED PROVIDER ORDER ENTRY

EXCLUSION:<100 RX DURING EHR REPORTING

MEASURE 2:

>30% LAB ORDERS CREATED USING COMPUTERIZED PROVIDER ORDER ENTRY

MEASURE 3:

>30% RADIOLOGY ORDERS CREATED USING COMPUTERIZED PROVIDER ORDER ENTRY

EXCLUSION 2&3: <100 ORDERS FOR EHR REPORTING PERIOD

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 4: ELECTRONIC PRESCRIBING

>50% OF PERMISSIBLE RX WRITTEN ARE QUERIED FOR DRUG FORMULARY AND ELECTRONICALLY TRANSMITTED USING CEHRT

EXCLUSION: <100RX DURING REPORTING OR NO PHARMACY WITHIN 10 MILES WHO EXCEPT ELECTRONIC RX AT BEGINNING OF REPORTING PERIOD

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 5: HEALTH INFORMATION EXCHANGE

TRANSITIONS/REFERS PATIENT TO ANOTHER CARE SETTING OF CARE/PROVIDER MUST:

1. USE CEHRT TO CREATE SUMMARY OF CARE RECORD
2. ELECTRONICALLY TRANSMIT SUMMARY TO RECEIVING PROVIDER FOR >10 PERCENT OF TRANSITIONS OF CARE/REFERRALS

EXCLUSION: TRANSFERS PATIENT TO ANOTHER SETTING/REFERS <100 TIMES FOR EHR REPORTING PERIOD

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 6: PATIENT SPECIFIC EDUCATION

PROVIDE PATIENT SPECIFIC EDUCATION RESOURCES IDENTIFIED BY CEHRT > 10 %
OF UNIQUE PATIENT OFFICE VISITS SEEN BY PHYSICIAN DURING EHR REPORTING
PERIOD

EXCLUSION: NO OFFICE VISITS DURING EHR REPORTING PERIOD

OBJECTIVE 6: PATIENT SPECIFIC EDUCATION



MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 7: MEDICATION RECONCILIATION

PERFORMS MEDICATION RECONCILIATION FOR >50 PERCENT OF TRANSITIONS OF CARE WHERE PATIENT IS TRANSITIONED INTO CARE OF EP

EXCLUSION: IF NOT RECIPIENT OF ANY TRANSITIONS OF CARE DURING EHR REPORTING PERIOD

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 8: PATIENT ELECTRONIC ACCESS

MEASURE 1:

>50 PERCENT OF UNIQUE PATIENTS SEEN DURING EHR REPORTING PERIOD HAS TIMELY ACCESS VIEW ONLINE, DOWNLOAD, & TRANSMIT TO THIRD PARTY THEIR HI SUBJECT TO PHYSICIAN'S DISCRETION TO WITHHOLD CERTAIN INFORMATION NO EXCEPTIONS

MEASURE 2:

AT LEAST 1 PATIENT SEEN DURING EHR REPORTING PERIOD VIEWS, DOWNLOADS OR TRANSMITS TO THIRD PARTY HI DURING EHR REPORTING PERIOD

EXCLUSIONS: PHYSICIAN NEITHER ORDERS/CREATES ANY OF INFORMATION LISTED AS PART OF MEASURES **OR** CONDUCTS $\geq 50\%$ ENCOUNTERS IN COUNTY WITHOUT ≥ 50 HOUSEHOLDS W/ 4MBPS BROADBAND AVAILABILITY PER FCC ON DAY 1 EHR REPORTING PERIOD

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 9: SECURE MESSAGING

- CAPABILITY FOR PATIENTS TO SEND/RECEIVE SECURE ELECTRONIC MESSAGE WITH PHYSICIAN WAS FULLY ENABLED DURING EHR REPORTING PERIOD
- FOR AT LEAST 1 PATIENT A SECURE MESSAGE WAS SENT USING THE ELECTRONIC MESSAGING FUNCTION OF EHR TO THE PATIENT, OR IN RESPONSE TO A SECURE MESSAGE SENT BY THE PATIENT DURING THE EHR REPORTING PERIOD.

EXCLUSION: NO OFFICE VISITS DURING EHR REPORTING PERIOD,

OR \geq 50% OF ENCOUNTERS IN COUNTY WITHOUT \geq 50 HOUSEHOLDS WITH 4MBPS BROADBAND AVAILABILITY ACCORDING TO FCC DAY 1 OF EHR REPORTING PERIOD

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 10: PUBLIC HEALTH REPORTING (MUST MEET 2/3)

MEASURE OPTION 1 – IMMUNIZATION REGISTRY REPORTING:

ACTIVE ENGAGEMENT WITH PH AGENCY TO SUBMIT IMMUNIZATION DATA

EXCLUSIONS: DOES NOT ADMINISTER ANY IMMUNIZATIONS TO POPULATIONS WHERE DATA IS COLLECTED OR NO IMMUNIZATION REGISTRY/IMMUNIZATION INFORMATION SYSTEM MEETING STANDARDS REQUIRED BY CEHRT DEFINITION ON DAY 1 EHR REPORTING PERIOD OR IN JURISDICTION WITHOUT IMMUNIZATION REGISTRY/IMMUNIZATION INFORMATION SYSTEM THAT HAS DECLARED READINESS AT START OF EHR REPORTING PERIOD

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 10: PUBLIC HEALTH REPORTING

MEASURE OPTION 2 – SYNDROMIC SURVEILLANCE REPORTING:

ACTIVELY ENGAGED WITH PH AGENCY TO SUBMIT SYNDROMIC SURVEILLANCE DATA

EXCLUSION: NOT PROVIDERS WHERE AMBULATORY SYNDROMIC SURVEILLANCE DATA IS COLLECTED OR WHERE NO PUBLIC HEALTH AGENCY CAPABLE OF RECEIVING ELECTRONIC SYNDROMIC SURVEILLANCE DATA AS REQUIRED BY CEHRT DEFINITION AT DAY 1 EHR REPORTING PERIOD OR OPERATES IN JURISDICTION WITHOUT READINESS OF PH AGENCY AT START OF EHR REPORTING PERIOD

MODIFIED STAGE 2 OBJECTIVES

OBJECTIVE 10: PUBLIC HEALTH REPORTING

MEASURE OPTION 3 (A&B) – SPECIALIZED REGISTRY REPORTING:

SUBMIT DATA TO SPECIALIZED REGISTRY

EXCLUSIONS: IF EP DOES NOT DIAGNOSE/TREAT ANY DISEASE/CONDITION ASSOCIATED WITH DATA THAT IS COLLECTED SPECIALIZED REGISTRY IN THEIR JURISDICTION DURING EHR REPORTING PERIOD OR NO SPECIALIZED REGISTRY CAN ACCEPT ELECTRONIC REGISTRY TRANSACTIONS AS REQUIRED BY CEHRT DEFINITION AT DAY 1 OF EHR REPORTING PERIOD OR NO SPECIALIZED REGISTRY HAS DECLARED READINESS TO RECEIVE ELECTRONIC REGISTRY TRANSACTIONS DAY 1 OF EHR REPORTING PERIOD

- **AOA MORE CAN ACHIEVE THIS MEASURE OBJECTIVE EVEN IF YOUR EHR IS NOT INTEGRATED WITH AOA MORE. JUST SIGN UP!**



ODS CAN NO LONGER BE EXCLUDED FROM OBJECTIVE 10

OBJECTIVE 10: PUBLIC HEALTH REPORTING

(SCHEDULED FOR STAGE 2 - 2015 - MEET 2/3)

MEASURE OPTION 3 – SPECIALIZED REGISTRY REPORTING:

SUBMIT DATA TO SPECIALIZED REGISTRY

EXCLUSIONS: IF EP DOES NOT DIAGNOSE/TREAT ANY DISEASE/CONDITION ASSOCIATED WITH DATA THAT IS COLLECTED SPECIALIZED REGISTRY IN THEIR JURISDICTION DURING EHR REPORTING PERIOD OR NO SPECIALIZED REGISTRY CAN ACCEPT ELECTRONIC REGISTRY TRANSACTIONS AS REQUIRED BY CEHRT DEFINITION AT DAY 1 OF EHR REPORTING PERIOD OR NO SPECIALIZED REGISTRY HAS DECLARED READINESS TO RECEIVE ELECTRONIC REGISTRY TRANSACTIONS DAY 1 OF EHR REPORTING PERIOD



REGISTRIES ARE IMPORTANT TO YOU!

- SIMPLIFIES PQRS
 - 62% OF ODS DID NOT DO PQRS IN 2013
 - GOT PENALIZED IN 2015
 - MORE ODS RECEIVING PENALTIES FROM 2015 REPORTING
 - SOFT APPEAL PROCESS NOVEMBER 2016
 - AOA IS WORKING WITH CMS TO ADDRESS 2015 PENALTIES FOR OPTOMETRY



EHR Participants



About Compulink Business Systems, Inc.
With more than 30 years of experience, Compulink has been a recognized leader in EHR and Practice Management systems for optometry. Used by more than 5,000 providers and 16 Colleges of Optometry, we offer the industry's most complete, best supported solution for EHR, Practice Management, billing services, and the best Optical POS available. For more information, visit www.compulinkadvantage.com or call 800-456-4522.



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Since 1994, MaximEyes by First Insight has been the most complete and customizable certified EHR—available on a private, secure cloud or local server option for one simple monthly fee. MaximEyes is ICD-10 compliant and helps thousands of eye care professionals increase revenue, reduce billing errors, improve patient retention, enhance office efficiency, and relieve the stress of regulatory requirements. To learn more, visit www.first-insight.com.



About RevolutionEHR:
RevolutionEHR is the leading provider of cloud-based electronic health record and practice management solutions for the optometric community. RevolutionEHR recognizes optometrists are not in the business of record keeping, accounting and maintaining complex IT systems. RevolutionEHR is an online solution that provides optometrists the freedom to focus on patient care. For more information, visit www.revolutionehr.com or call 1-877-REVEHR1.

Coming in Q-1 2016:



About Eyefinity:
Eyefinity provides a proven software platform to streamline the everyday complexities of managing an optometric practice with integrated practice management, EHR, claims processing and patient engagement capabilities. Along with its on-premises and cloud-based solutions, Eyefinity offers professional services such as revenue cycle management and business insights to address the needs of single and multi-location practices. For more information, visit www.eyefinity.com or call 800.269.3666.



About Practice Director:
Practice Director EHR provides what no other EHR system can – a true integration of practice management expertise with a fast and flexible EHR system. Practice Director is ONC-ATCB certified for Meaningful Use and is seamlessly integrated with all practice management functionality, including demographics, scheduling, billing, optical, reports, and EHR. Visit www.PracticeDirector.com for more information.

Also coming soon:

- Crystal Practice Management
- My Vision Express



OTHER AOA MORE BENEFITS

- BENCHMARK AND OUTCOMES
 - HELPING YOU IN YOUR EXAM ROOM TO SEE HOW YOU COMPARE TO ODS ACROSS THE COUNTRY
- ADVOCACY
 - OPTOMETRY WRITES IT'S OWN SCRIPT!
 - GIVES US INFORMATION ABOUT OUR OWN CARE
- EVIDENCE-BASE



COST OF AOA MORE

- \$0.00 FOR AOA MEMBERS!
 - \$0 CHARGED BY AOA
 - COMPULINK IS CHARGING \$10/MONTH PER DOC
 - NO OTHER VENDOR IS CHARGING FOR YOUR USE OF AOA MORE
 - \$1,800 PER YEAR FOR NON-MEMBERS

CLINICAL QUALITY MEASURES

- NO THRESHOLDS TO MEET—SIMPLY HAVE TO REPORT DATA ON CQM
- NO CALCULATIONS FOR CQM!
- CERTIFIED EHR WILL PRODUCE

**BUT MUST ENTER DATA EXACTLY AS YOUR CERTIFIED EHR
PRODUCED IT SO IT IS REPORTED PROPERLY**

CQM 2016 MODIFIED STAGE 2

- MUST REPORT ON 9/64 APPROVED CQMS
 - RECOMMENDED CORE CQMS ENCOURAGED BUT NOT REQUIRED
 - 9 CQMS FOR ADULT POPULATION (MANY NOT APPROPRIATE FOR OPTOMETRY PRACTICE)
 - 9 CQMS FOR PEDIATRIC POPULATION
 - NQF 0018 STRONGLY ENCOURAGED SINCE CONTROLLING BLOOD PRESSURE IS HIGH PRIORITY GOAL IN MANY NATIONAL HEALTH INITIATIVES
- CANNOT BE EXCLUDED FROM REPORTING 9 CQM BUT ZERO IS AN ACCEPTABLE VALUE TO REPORT **HOWEVER**, FOR **PQRS EHR** REPORTING OPTION, YOU MUST REPORT AT LEAST 1 MEASURE TO MEET PQRS REQUIREMENTS

CQM 2016: FOR 92000/99000 CODES

1. PREVENTIVE CARE AND SCREENING: TOBACCO USE: SCREENING AND CESSATION INTERVENTION (POPULATION/PUBLIC HEALTH)
2. DIABETES: EYE EXAM (CLINICAL PROCESS/EFFECTIVENESS)
3. PRIMARY OPEN-ANGLE GLAUCOMA (POAG): OPTIC NERVE EVALUATION (CLINICAL PROCESS/EFFECTIVENESS)
4. **DIABETIC RETINOPATHY: DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY(CLINICAL PROCESS/EFFECTIVENESS)**
5. DIABETIC RETINOPATHY: COMMUNICATION WITH THE PHYSICIAN MANAGING ONGOING DIABETES CARE (COMMUNICATION/CARE COORDINATION)

CQM 2016: FOR 92000/99000 CODES

6. DOCUMENTATION OF CURRENT MEDICATIONS IN THE MEDICAL RECORD (PATIENT SAFETY)
7. CLOSING THE REFERRAL LOOP: RECEIPT OF SPECIALIST REPORT (CARE COORDINATION)
8. HEMOGLOBIN A1C TEST FOR PEDIATRIC PATIENTS (CLINICAL PROCESS/ EFFECTIVENESS)
9. PREVENTIVE CARE AND SCREENING: SCREENING FOR HIGH BLOOD PRESSURE AND FOLLOW UP DOCUMENTED (POPULATION/ PUBLIC HEALTH)

CQM 2016: FOR 99000 CODES ONLY

1. PREVENTIVE CARE AND SCREENING: BODY MASS INDEX (BMI) SCREENING AND FOLLOW-UP PLAN (POPULATION/PUBLIC HEALTH)
2. IMPROVEMENT IN BLOOD PRESSURE (CLINICAL PROCESS/EFFECTIVENESS)
3. CONTROLLING HIGH BLOOD PRESSURE (CLINICAL PROCESS/EFFECTIVENESS)
4. PREVENTIVE CARE AND SCREENING: INFLUENZA IMMUNIZATION
(POPULATION/PUBLIC HEALTH)
5. PNEUMONIA VACCINATION STATUS FOR OLDER ADULTS
(CLINICAL PROCESS/ EFFECTIVENESS)



Attestation Approved Email

Medicare EHR Incentive Program Attestation Status Update

noreply@ehrincentives.cms.gov

Sent: Thursday, January 28, 2016 at 11:06 AM

To: sfe@bytheshore.com

This email is to inform you that your Attestation for the Medicare Electronic Health Record (EHR) Incentive Program is 'Accepted'.

Attestation Tracking Information

Attestation Confirmation Number: 1000959068

Name: Harvey B Richman

NPI: 1336124445

EHR Certification Number: 1314E01RAPDNEAH

EHR Reporting Period: 10/01/2015 - 12/31/2015

Program Year: 2015

Attestation Status Date: 01/28/2016

Attestation Status Reason:

The EP demonstrates meaningful use of certified EHR technology.

AUDIT NOTICE EMAIL ONLY

- **FROM: MEANINGFUL USE (FIGLIOZZI & CO.)]**
- **SUBJECT: HITECH MEANINGFUL USE PREPAYMENT AUDIT FOR DR. RICHMAN (NPI#1154306264) IMPORTANCE: HIGH**
- **...SELECTED BY CMS** FOR A HITECH EHR MEANINGFUL USE PREPAYMENT AUDIT FOR PAYMENT YEAR 3. *SINCE THIS IS A PREPAYMENT AUDIT YOUR INCENTIVE PAYMENT WILL BE HELD PENDING THE OUTCOME OF THIS AUDIT.* WE ARE THE CMS CONTRACTOR AUTHORIZED TO PERFORM THE AUDIT.
- PLEASE **CONFIRM YOUR RECEIPT** OF THIS E-MAIL. ALSO, PLEASE CONFIRM WHETHER YOU WILL BE THE CONTACT PERSON FOR THIS AUDIT. IF YOU WILL BE THE CONTACT PERSON, PLEASE SUPPLY YOUR PREFERRED CONTACT INFORMATION FOR FUTURE CORRESPONDENCE. IF YOU ARE NOT THE CONTACT PERSON FOR THIS AUDIT, PLEASE ADVISE US WHO AT YOUR FACILITY IS THE CORRECT CONTACT PERSON AND FURNISH THEIR E-MAIL ADDRESS.
- **DEADLINES FOR RESPONDING ALSO LISTED**

Audit Approval Email

**RE: HITECH EHR Meaningful Use
Audit Determination Letter
NPI: 1154306264
Attestation Period: 7/1/2014 - 9/30/2014
Program Year: 2014
Payment Year: 3**

Dear Dr. Richman

We have completed our audit of how you demonstrated meaningful use of certified Electronic Health Record (EHR) technology in accordance with Section 13411 of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), as included in Title XIII, Division A, Health Information Technology and in Title IV of Division B, Medicare and Medicaid Health Information Technology of the American Recovery and Reinvestment Act of 2009. The HITECH Act provides the Secretary, or any person or organization designated by the Secretary, the right to audit and inspect any books and records of any organization eligible to receive an incentive payment.

We performed a review of your meaningful use attestation for the Program Year 2014 and Payment Year 3. Based on our review of the supporting documentation furnished by you, we have determined that you **have met** the meaningful use criteria.

Please also note that this audit does not preclude you from future, prior or subsequent year audits.

Sincerely,

PROPOSED MIPS EHR MU CHANGES

- ADVANCING CARE INFORMATION PERFORMANCE CATEGORY
- COUNTS FOR 25% OF TOTAL MIPS SCORE

BASE SCORE + PERFORMANCE SCORE + BONUS POINT = COMPOSITE SCORE

50 POINTS + 80 POINTS + UP TO 15 PERCENT=> 100 POINTS → 25%

The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points

MIPS CHANGES

- EXCLUSIONS FOR LOW VOLUME
- NO STAND ALONE CQM REPORTING
- NEW CATEGORY FOR CLINICAL PRACTICE IMPROVEMENT

SCORING: MINIMUM REQUIREMENTS

- CLINICAL PRACTICE IMPROVEMENT ACTIVITIES (NEW)
 - 15% OF SCORE
 - MOST PARTICIPANTS ONLY NEED TO ATTEST THAT YOU COMPLETED UP TO 4 IMPROVEMENT ACTIVITIES FOR A MINIMUM OF 90 DAYS
 - GROUPS WITH <15 PARTICIPANTS AND RURAL OR HEALTH PROFESSIONAL MUST ATTEST COMPLETION OF 2 ACTIVITIES FOR A MINIMUM OF 90 DAYS
- ADVANCING CARE INFORMATION (~MEANINGFUL USE)
 - 25% OF SCORE
 - FULFILL THE REQUIRED MEASURES FOR A MINIMUM OF 90 DAYS:
- CHOOSE TO SUBMIT UP TO 9 MEASURES FOR A MINIMUM OF 90 DAYS FOR ADDITIONAL CREDIT.

SCORING: MINIMUM REQUIREMENTS

- COSTS CATEGORY (~VBMS)-WILL NOT BE REQUIRED IN 2017
- QUALITY PERFORMANCE MEASURE (~PQRS):
 - 60% OF SCORE
 - FOR A MINIMUM OF 90 DAYS THERE ARE THREE OPTIONS FOR FULL PARTICIPATION:
 - REPORT 6 QUALITY MEASURES
 - NO CROSS CUTTING MEASURE REQUIRED

ADVANCING CARE INFORMATION PERFORMANCE CATEGORY (ACIPC)

- **BASE SCORE = 50 POINTS**

**To receive the base score, physicians must simply
provide the numerator/denominator or yes/no for each
objective and measure**

ADVANCING CARE INFORMATION PERFORMANCE CATEGORY (ACIPC) SUMMARY

Summary:

- ✓ **Scoring based on key measures of health IT interoperability and information exchange.**
- ✓ **Flexible scoring for all measures to promote care coordination for better patient outcomes**
- ✓ **Key Changes from Current Program (EHR Incentive):**
 - **Dropped "all or nothing" threshold for measurement**
 - **Removed redundant measures to alleviate reporting burden.**
 - **Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives**
 - **Reduced the number of required public health registries to which clinicians must report**
 - **Year 1 Weight: 25%**

ADVANCING CARE INFORMATION 2017

- 4 MEASURES INCLUDED
 - SECURITY RISK ANALYSIS
 - E-PRESCRIBING
 - PROVIDE PATIENT ACCESS
 - HEALTH INFORMATION EXCHANGE

2017 PERFORMANCE SCORE ACI

- 6 MEASURES
 - PROVIDE PATIENT ACCESS
 - PATIENT-SPECIFIC EDUCATION
 - VIEW, DOWNLOAD, OR TRANSMIT
 - SECURE MESSAGING
 - HEALTH INFORMATION EXCHANGE
 - MEDICATION RECONCILIATION

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES

- NEW CATEGORY FOCUSED ON IMPROVING PUBLIC HEALTH
- CMS HAS LIST OF 90 PLUS ACTIVITIES TO CHOOSE FROM
- MANY CAN BE COMPLETED BY ENGAGING WITH A QUALIFIED CLINICAL DATA REGISTRY, SUCH AS AOA MORE

PROPOSED MIPS: CLINICAL PRACTICE IMPROVEMENT

COULD INCLUDE CARE COORDINATION, SHARED **DECISION** MAKING, SAFETY CHECKLISTS, EXPANDED PRACTICE ACCESS

Summary:

- ✓ **To not receive a zero score, a minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities**
- ✓ **Full credit for patient-centered medical home**
- ✓ **Minimum of half credit for APM participation**
- ✓ **Key Changes from Current Program:**
 - **Not applicable (new category)**
 - **Year 1 Weight: 15%**

CLINICAL PRACTICE IMPROVEMENT

1. EXPAND PRACTICE ACCESS-SAME DAY APPOINTMENTS FOR URGENT NEEDS AND AFTER HOURS ACCESS TO CLINICIAN ADVICE
2. POPULATION MANAGEMENT-MONITORING HEALTH CONDITIONS OF INDIVIDUALS TO PROVIDE TIMELY HEALTH CARE INTERVENTIONS OR PARTICIPATE IN QCDR
3. CARE COORDINATION -TIMELY COMMUNICATION OF TESTS RESULTS, TIMELY EXCHANGE OF CLINICAL INFORMATION TO PATIENTS OR OTHER CLINICIANS AND USE OF REMOTE MONITORING OR TELE-HEALTH
4. BENEFICIARY ENGAGEMENT-ESTABLISHMENT OF CARE PLANS FOR INDIVIDUALS WITH COMPLEX ARE NEEDS.
5. PATIENT SAFETY AND PRACTICE ASSESSMENT -USE OF CLINICAL OR SURGICAL CHECKLISTS AND PRACTICE ASSESSMENTS RELATED TO MAINTAINING CERTIFICATION.

VALUE BASED MODIFIER (VBM)

- WHAT IT IS **NOT**
 - NOT A CODING MODIFIER ADDED TO CLAIMS
- WHAT IT **IS**
 - COMPILATION OF QUALITY AND EFFICIENCY DATA
 - IMPACTS **ALL** MEDICARE PHYSICIANS
 - BEGAN IN 2015 (YES LAST YEAR) & WILL IMPACT MAJORITY OF OPTOMETRISTS
 - 2018 REIMBURSEMENT IMPACT BASED ON 2016 PERFORMANCE
 - COMPILES INDIVIDUAL PHYSICIAN'S CARE COSTS COMPARED TO OUTCOMES
 - AT RISK FOR BEING PAID LESS THAN USUAL MEDICARE FEE-FOR-SERVICE RATES

VALUE BASED MODIFIER (VBM)

- **HOW** VBM IMPACT IS DETERMINED?

CMS ANALYSIS FOR PHYSICIAN'S SCORE CATEGORIZED:

1. QUALITY: LOW QUALITY, AVERAGE QUALITY OR HIGH QUALITY.

2. COST: LOW COST, AVERAGE COST, HIGH COST.

PHYSICIANS WILL RECEIVE REIMBURSEMENT BASED ON SCORE

- a) INCREASE REIMBURSEMENT
- b) NO CHANGE IN REIMBURSEMENT
- c) REIMBURSEMENT PENALTY

VBM 2016

- **WHAT TO DO IN 2016 TO AVOID VBM PAYMENT PENALTIES IN 2018??**

RW9

- PARTICIPATE AND MEET PQRS IN 2016 !
- WHERE HAVE YOU HEARD THIS OVER AND OVER AGAIN????

- **FROM 2015 AND ON:**

- **IF DO NOT PARTICIPATE IN PQRS, THEN BOTH PQRS PENALTY AND VBM PENALTY**

PQRS PENALTY = 2%

VBM PENALTY:

- SOLO AND 2 TO 9 EPS GROUPS PENALTY= 2% → **TOTAL 4%**
- 10 + EPS GROUPS PENALTY=4% → **TOTAL 6%**

Slide 82

RW9 Is this correct for 2016 performance year?

Rebecca Wartman, 2/4/2016

COSTS

- **2017**
 - CMS WILL COMPARE COSTS OF CARE WITH OTHER PHYSICIANS
 - PROVIDE FEEDBACK ON PERFORMANCE
 - PERFORMANCE WILL NOT FACTOR INTO SCORE FOR THE 2017 PERFORMANCE YEAR.
- **2018**
 - SCORES RELATED TO COST WILL CONTRIBUTE TO 10 PERCENT OF TOTAL SCORE
- **2019 AND BEYOND**
 - COST WILL ACCOUNT FOR 30 PERCENT OF SCORE.
- LOOK FOR MORE INFORMATION ON THE COST CATEGORY IN FUTURE AOA PUBLICATIONS.

PHYSICIAN COMPARE

Centers for Medicare and Medicaid Services (CMS) website

- Find & choose physicians/other health care professionals enrolled in Medicare
- Can make informed choices about health care you get (required by Affordable Care Act (ACA) of 2010)
- Can compare group practices
- Will be able to compare individual physicians and other qualified health care providers (coming)

American Board of Optometry (ABO) Board Certification will be added to Physician Compare website

PHYSICIAN COMPARE

For physician, other health care professional, or group practice's information to appear on Physician Compare:

1. Current and "approved" status PECOS Enrollment records
2. Valid physical location or address identified
3. Valid specialty must be identified
4. Professional must have National Provider Identifier (NPI)
5. Individual provider must have submitted at least 1 Medicare Fee-for-Service claim within last 12 months
6. Group practice must have at least 2 approved health care professionals reassigning their benefits to group

PHYSICIAN COMPARE

Primary specialty: Optometry

Print all information

Add to My Favorites

Is this you?
Update your information here.


General information

Locations

Quality programs:

- ✓ 2013 Physician Quality Reporting System (PQRS) ⓘ
- ✓ 2013 Electronic Prescribing (eRx) Incentive Program ⓘ
- ✓ 2013 Electronic Health Records (EHR) ⓘ

[View information about Medicare quality reporting programs](#)

HARVEY RICHMAN 

Primary specialty: Optometry [Print all information](#)


[Add to My Favorites](#) [Is this you?](#)
Go here to learn how to update your information.

General information


Locations

Clinical quality of care

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.** 

[View information about quality activity participation.](#)

Board certification: American Board of Optometry 

Gender: Male

Education: Graduated: 1991
School: NEW ENGLAND COLLEGE OF OPTOMETRY

HARVEY RICHMAN 

Primary specialty: Optometry [Print all information](#)

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Go here to learn how to update your information.

General information

Locations



Clinical quality of care

These clinical quality of care measures are reported by eligible health care professionals. Health care professionals report these measures to Medicare. A selection of these quality measures are publicly reported on this website to help consumers make informed decisions and to encourage health care professionals to improve the quality of care they provide to patients. It is important to understand that not all health care professionals report the same measures, and the measures available to report are different depending on the types of services a physician or other health care professional provides to patients. Reporting more or less measures is not a reflection of the quality of care given to patients. ([Get more information.](#))

More stars are better. Select a measure to read more information.

Preventive care: General health

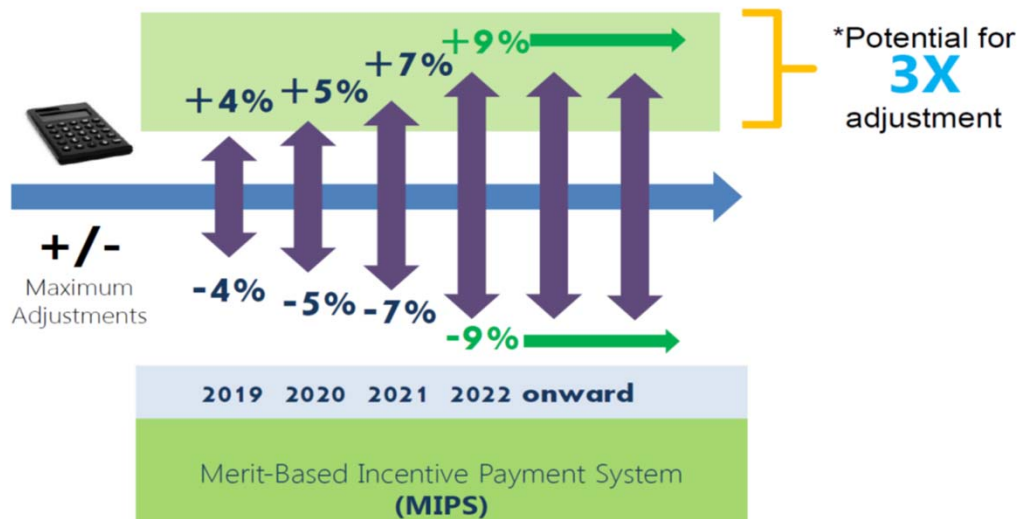
Some health care professionals do a better job than others providing care that keeps patients healthy. Medicare gave this health care professional a performance score based on how well this health care professional did on each measure. The scores are presented as stars and as a percent.

▶ Screening for tobacco use and providing help quitting when needed.	 100%
▶ Screening for high blood pressure and developing a follow-up plan.	 100%

PROPOSED MIPS CHANGES - RESOURCES

- FINAL CATEGORY TO CONSIDER IS COST REPLACING CURRENT VBM PROGRAM
- CMS WILL CALCULATE BASED ON CLAIMS
- PROVIDER DOES NOT SUBMIT ANYTHING
- CMS TAKES THE AVERAGE OF ALL COST MEASURES AVAILABLE
- **COST WILL BE TRACKED BUT NOT COUNTED FOR THE FINAL PERFORMANCE WEIGHTED SCORE IN 2017**

REAL IMPACT OF MIPS ON REIMBURSEMENT



IT COULD BE WORSE



SO, ... HOW'S YOUR DAY GOING?

SUMMARY OF 2016 PENALTIES

- **PQRS FAILURE TO PARTICIPATE** -2% MPFS
- **MEDICARE EHR MEANINGFUL USE FAILURE** -3% MPFS
- **VALUE BASED MODIFIER NON-PQRS PARTICIPANTS**
 - NON- PQRS SOLO AND 2-9 PROVIDER GROUPS -2% MPFS
 - NON-PQRS 10+ PROVIDER GROUPS -4% MPFS
- **VALUE BASED MODIFIER PQRS PARTICIPANTS**
 - PQRS SOLO AND 2-9 PROVIDER GROUPS 0% - +2X MPFS (X=QUALITY TIERING)
 - PQRS 10+ PROVIDER GROUPS -4% - +4X MPFS (X= QUALITY TIERING)
 - GROUPS/SOLO ELIGIBLE FOR EXTRA +1X MPFS IF IN TOP 25% QUALITY TIERING

POTENTIAL TO LOSE 7-9% OF YOUR MEDICARE REIMBURSEMENT

HOW ABOUT A HUG



AOA INPUT

- CMS SAYS THERE ARE 36,385 DOCTORS OF OPTOMETRY IN MEDICARE, AND ABOUT TWO-THIRDS WILL BE EXCLUDED FROM MIPS IN 2017
- 12,000 (WHO AVERAGE \$75K IN MEDICARE INCOME) WILL BE INCLUDED, AND ONLY ABOUT 10% WILL BE PENALIZED CMS PREDICTS.
- CMS NOW PREDICTS ABOUT TWICE AS MUCH BONUS DOLLARS WILL FLOW TO OPTOMETRY THAN PENALTIES, RESULTING IN \$4-5 MILLION NET FOR THE PROFESSION
- THE BONUS AMOUNTS WILL BE VERY SMALL, LIKE PQRS.

CMS BRANDED 2017 AS A “TRANSITION YEAR”

- **FEE SCHEDULE UPDATE FOR 2017 AND 2018 IS 0.5% BY LAW**
- **FEE-FOR-SERVICE PAYMENTS NOT ENOUGH TO OFFSET THE RISING COSTS OF PROVIDING CARE**
- **MAINTAINED A 1-YEAR PERFORMANCE PERIOD FOR MAXIMUM INCENTIVE**

RESOURCES

CMS MODIFIED STAGE 2 RESOURCE

[HTTP://WWW.CMS.GOV/REGULATIONS-AND-GUIDANCE/LEGISLATION/EHRINCENTIVEPROGRAMS/STAGE_2.HTML](http://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/stage_2.html)

AOA MEANINGFUL USE RESOURCES

[HTTP://WWW.AOA.ORG/OPTOMETRISTS/TOOLS-AND-RESOURCES/MEDICAL-RECORDS-AND-CODING/MU](http://www.aoa.org/optometrists/tools-and-resources/medical-records-and-coding/mu)

AOA VALUE BASED MODIFIER RESOURCES

[HTTP://WWW.AOA.ORG/ADVOCACY/FEDERAL-ADVOCACY/REGULATORY-ISSUES/MEDICARE/CMS-VALUE-BASED-PAYMENT-MODIFIER](http://www.aoa.org/advocacy/federal-advocacy/regulatory-issues/medicare/cms-value-based-payment-modifier)

AOA ADVOCACY ACO TOOLKIT

[HTTP://WWW.AOA.ORG/ADVOCACY/ABOUT-THE-THIRD-PARTY-CENTER/ACO-RESOURCE-TOOLKIT](http://www.aoa.org/advocacy/about-the-third-party-center/aco-resource-toolkit)

AOA CODING RESOURCES INCLUDING PQRS

[HTTP://WWW.AOA.ORG/CODING](http://www.aoa.org/coding)

CONTACTS AND WEBSITES

- MOST MATERIAL REFERENCED ON WEB
- USE AVAILABLE TOOLS
 - CPT, ICD-10-CM, HCPCS
- USE AOACODINGTODAY.COM
 - INSTANT UPDATES
 - EXTRA CODING TOOLS
 - NOTES
 - CLARIFICATIONS

WWW.AOA.ORG/CODING

THANK YOU !!!!!

WWW.AOA.ORG/CODING