THE ALPHABET SOUP OF OPHTHALMOLOGY

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The presenter provides practice management, operations, leadership and business development consulting services to eye care practices

MACRA

The Medicare Access and CHIP Reauthorization Act (MACRA) is ushering in the biggest change to Medicare physician payment in decades. As proposed, physicians will begin reporting through the Merit-Based Incentive Payment System (MIPS) in January 2017.
ADVANCED APMS

Under MACRA, physicians have the opportunity to receive a 5% bonus to Medicare physician payments for participating in certain advanced APMs. To qualify as an advanced APM, the model must incorporate quality measures, the use of EHR technology, and have two-sided risk. In order to receive the 5% bonus, physicians must meet yearly thresholds for the percentage of patients or revenues covered by the APM. For 2019 payment, based on 2017 performance, 25% of Medicare revenues or 20% of Medicare patients must be from an APM. Beginning in 2021, CMS will allow non-Medicare patients and revenues to be included toward the thresholds; however, the thresholds continue to increase, up to 75% of revenues or 50% of patients by 2023.

MIPS

Most ophthalmologists will participate in the MIPS program. The MIPS program will be based on four performance categories: quality, resource use, advancing care information, and clinical practice improvement activities. Three existing Medicare reporting programs are being used to make up the categories:

- Physician Quality Reporting System (PQRS) has become the quality category.
- Value-based Payment Modifier (VBM) program has become the resource use category.
- MU program is becoming the advancing care information category.
- Clinical practice improvement activities will be a new category.
Review your current and recent PQRS reporting system and feedback reports. Feedback reports are available through the CMS Enterprise Portal. All current ophthalmology-specific PQRS measures are proposed to be available for reporting in MIPS. Determine what measures you currently report and in which you are most successful. MIPS includes a key change to reward physicians for achievement of quality benchmarks for the measures, not just requiring the measures be reported.

If you have been reporting a PQRS measures group, such as for cataract or diabetic retinopathy, be prepared for a significant increase in the number of patients to report. Have urged that they be reinstated, they may not be available to report for 2017. Under the current MIPS proposal, physicians reporting via registry must report on 90% of all patients, not just Medicare, and if through claims, 80% of Medicare patients. Carefully consider what measures are available to report through your chosen reporting method, as some measures may be registry-only.

Review current and recent Quality and Resource Use Reports (QRUR), which are used to determine the current Value-Based Payment Modifier, and also available through the CMS Enterprise Portal. While the two cost measures proposed to remain as part of MIPS—Total per Capita Cost and Medicare Spending per Beneficiary—are out of an individual physician’s control, the QRUR report will give you an idea of how you might fare on these measures under MIPS. CMS will calculate these measures through claims, and physicians are not required to report additional information to meet the measures.

If available, review your 2014 Supplemental QRUR for information about your practice’s relative cost of providing cataract surgery. CMS has used 2014 data to calculate practices’ resource use through several procedure and condition-based episode groups, including cataract surgery. The episode groups—which are currently only for information purposes—attempt to compare your practice’s total cost of caring for a cataract patient to national and regional benchmarks. MACRA requires CMS to develop episode-based resource use measures to account for a significant portion of Medicare spending, and CMS is currently in the process of developing them.
ADVANCED CARE INFORMATION 25%

Determine whether you have 2014- or 2015-certified EHR technology (CEHRT). Providers with 2014 CEHRT will not be able to report on ACI measures that correlate to Stage 3 of Meaningful Use, and therefore, must report on Modified Stage 2 measures and objectives in 2017. Providers with 2015 or a combination of 2014 or 2015 CEHRT may choose to report on Modified Stage 2 measures and objectives in 2017 as well.

Plan to conduct a security risk analysis in early 2017 to satisfy the proposed ACI requirement.

Review current administrative or clinical procedures for Meaningful Use. Review objectives and measures your practice is currently working to meet, or has met in the past. CMS is proposing to maintain measures that many ophthalmologists have struggled to meet in the past, including patient engagement and information exchange. To meet the base ACI score, you must have a “1” in the numerator of the measures, but to achieve performance points toward the total available ACI score, physicians will have to demonstrate additional achievement in the patient electronic access, coordination of care through patient engagement, and information exchange objectives and measures.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES 15%

This is a new category and does not correlate to any existing quality reporting program. Review the current list of proposed activities and determine which might work for your practice. Practices with 15 or fewer providers must only report on two CPIAs.

If you participate, or are considering participating in, a clinical data registry, check to see what CPIAs you may be able to achieve through the registry.

PATIENT RELATIONSHIP CODES

MACRA requires CMS to develop a series of codes physicians will report on Medicare claims to indicate the type and level of relationship they have with specific patients. Patient relationship codes will be used to attribute the costs of caring for individual patients to their physicians to determine resource use.

CMS has proposed several categories under which the patient relationship codes will fall, such as acute care versus ongoing chronic care, and whether the physician is the primary provider managing care or consulting.

The specific codes that must be reported have not yet been proposed. MACRA requires the patient relationship codes to be reported on claims beginning in 2018. CMS is expected to propose the list of codes in the fall of 2016.
EPISODE GROUPS

In order to better measure resource use and, in the future, be used for Medicare payment, MACRA requires CMS to develop episode groups (or groupers) based on specific episodes of care for certain procedures and chronic conditions. Current resource use measures are primary care-based, and so MACRA intended that the episode groups cover a wider array of physician services to impact a greater percentage of Medicare physician reimbursement, including specialty services. Since ophthalmology has a high volume of Medicare procedures, it is likely that several episode groups will be developed for ophthalmic procedures and conditions.

BONUSES & PENALTIES

For 2019, the maximum penalty is capped at -4%. For the following years, penalties will be capped at: -5% in 2020, -7% in 2021, and -9% in 2022. Bonuses for each of the years are up to three times the annual cap for each year’s penalty—with the potential for additional bonuses of 10% for exceptional performance.
ARE YOU READY?

If you are not already participating in a qualified clinical data registry, consider signing up with your EHR vendor to inquire about its plan for implementing MACRA. Determine what capabilities your system will offer for reporting some, or all, MIPS data. Be sure to document these conversations.

Physicians may participate in MIPS as an individual or group. Consider which option might work better for your practice.

While all physicians must participate in MIPS in the first performance year, you should consider whether you may choose to participate as an advanced APM or take advantage of the flexibilities, or whether you will continue to participate in future years. Be sure to consider the requirements for APM participation increase steadily in the coming years. For 2019 payment, based on 2017 performance, 90% of Medicare revenues or 20% of Medicare patients must be from an APM to receive the 4% bonus. Beginning in 2021, CMS will allow non-Medicare patients and revenues to be included toward the thresholds, however, the thresholds continue to increase, up to 75% of revenues or 50% of patients by 2023. In addition, advanced APMs must include quality and EHR components and have two-sided risk. Some ophthalmologists participate in the Medicare Shared Savings Track 1 ACOs, but since these models do not include two-sided risk, they are not considered advanced APMs. If you already participate in an ACO, determine whether it will qualify as an advanced APM and whether you are likely to meet the patient or revenue thresholds.

Determine if you qualify for a low-volume exemption. CMS proposes to exempt providers from MIPS who charge $10,000 or less in Medicare and treat 100 or fewer Medicare patients annually. However, it is unclear how much time this exemption will be available and whether it will qualify for this exemption, due to the high percentage of Medicare patients seen by ophthalmologists.

What else is in MACRA?

**What’s the Social Security Number Removal Initiative?**

Removal of Social Security Numbers (SSNs) from all Medicare cards.

**What’s the CMS Quality Measure Development Plan (MDP)?**

Our Quality Measure Development Plan (MDP), required by MACRA section 102, is a focused framework to help us build and improve quality measures for clinicians. These quality measures will support MIPS and advanced APMs.

WHAT NOW?

**WHAT IS THE FLEXIBILITY ANNOUNCEMENT?**

**WE HAVE OPTIONS:**

1) Any data reported will allow providers to avoid a negative payment adjustment. The goal is to ease providers into broader participation in the following two years.

2) Submit data for a reduced number of days. This means their first performance period could begin later than Jan. 1 and that practice could still qualify for a small payment if it submits data on how the practice is using technology and how it’s improving.

3) The third option is for practices that are ready to go in 2017.

4) The final option is to participate in an advanced alternative payment model such as a Medicare Shared Savings ACO.
MAKE IT PERSONAL

MACRA is the most significant change in Medicare reimbursement in decades. The timeline for implementation is aggressive. While the final rule is not expected to be released until sometime this fall of, we should begin preparation now, as CMS has proposed to use performance data from 2017 and lack of compliance with reporting could result in penalties.

About Pat Morris

I have twenty-six years management experience with approximately twenty-three years concentrated in ophthalmology. In addition to my formal education I have completed more than 330 hours in ophthalmic administration. With my ophthalmic specific experience in budgeting, accounts receivable, accounts payable, collections, general accounting, purchasing and inventory control, information systems, medical records, contract negotiations and marketing I am qualified to assist. My strengths are my diplomatic managerial style, proficiency in operations, revenue cycle experience and business development expertise.

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