MIPS MADNESS

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The 2019 Rules!!

Disclosures

- Drs. Michaels & Wroten have no financial disclosures for the content of this presentation
- Drs. Michaels and Wroten hold zero financial benefit from AOA MORE (optometry's registry)
- Dr. Michaels is Past-Chair of the AOA MORE committee
- Dr. Wroten serves on the AOA Federal Relations Committee
- Thank you Kara Webb, AOA DC Office

Disclaimer

- The points contained herein are based on current regulations
- Drs. Michaels & Wroten want you to learn this material to improve your practice performance & have made the slides available for you to learn
- However…

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What is MIPS?

MIPS combines three legacy programs—Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals, Physician Quality Reporting System, and the Value-Based Payment Modifier—into a single, improved program.
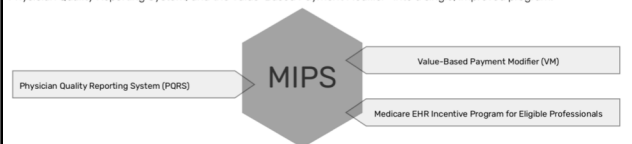
Who Participates in the Quality Payment Program?
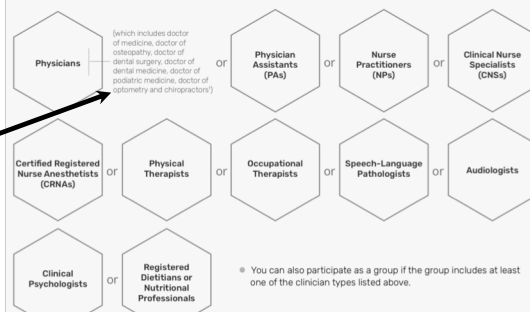
2019 MIPS Executive Summary for the Experienced

- Bipartisan Budget Act of '18
  - Allowed gradual transition in MIPS for 3 more years
  - For year 3, finalizing Cost performance category at 15 points
  - Flexibility in establishing performance threshold for program yrs 3/4/5, then estimated threshold of final score mean or median for prior period in year 6
- CMS set 2019 Performance Threshold=30 pts (Super Threshold=75 pts)
- New Category Weights: Quality=45%, PI=25%, Cost=15%, IA=15%
- Max payment adjustment=+/-7%

2019 Executive Summary for the Experienced

- Opt-in if meet/exceed at least 1 of the low-volume threshold criteria
- Retained/increased some bonus points (e.g. small practice bonus now 6 points in Quality category instead of to overall score)
- Continuing 3 points awarded to small practices for submitted quality measures not meeting data completeness requirements
- Continuing to provide small practices option of Virtual Group
- No-cost, customized support to small/rural practices thru Small, Underserved, & Rural Support (SURS) technical assistance initiative

2019 Executive Summary for the Experienced

- Facility-based scoring option for facility-based clinicians
- New Terms:
  - Collection Type - set of quality measures with compares specs & data completeness criteria
  - Submitter Type - the MIPS eligible clinician, group, or 3rd party intermediary acting on behalf of a MIPS eligible clinician or group that submits data on measures & activities
  - Submission Type - mechanism by which the submitter type submits data to CMS

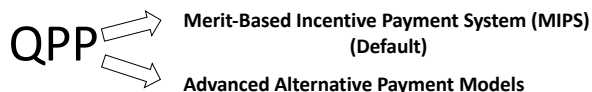## 2019 Executive Summary for the Experienced

- Quality:
  - Some commonly reported measures worth less

- Improvement Activities (IA):
  - New IA specifically for eye care – thanks to AOA!

- Cost:
  - No changes (aside from weighting in overall score now 15%)

2019 Executive Summary for the Experienced

- Performance Improvement (PI):
  - Must use 2015 CEHRT
  - Eliminated base, performance, & bonus scores - now based on performance (& SRA required without points for doing)
  - 4 objectives:
    - eRx
    - Health Information Exchange (HIE)
    - Provider to Patient Exchange
    - Public Health & Clinical Data Exchange

CMS Game Changer

- MACRA
  - Medicare Access and CHIP Reauthorization Act of 2015

QPP ⇒ **Merit-Based Incentive Payment System (MIPS) (Default)**

Advanced Alternative Payment Models

2015 MACRA Legislation

- Permanently repealed SGR
- Cost neutral legislation
- Annual fee schedule increase of 0.5% only through 2019

- Bundles: PQRS, MU, VBM
- Quality Payment Program (QPP)
  - Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Model (APM)

MACRA New Language

Old School
- PQRS
- MU
- VBM
- ____

New School
- Quality
- Promoting Interoperability (PI)*
- Cost
- Improvement Activities (IA)

* Previously Advancing Care Information (ACI)

MACRA New Language

Old School
- PQRS
- MU
- VBM
- ____

New School
- **Quality**
- **Promoting Interoperability (PI)**
- **Cost**
- **Improvement Activities (IA)**

NEW or a CHANGE for 2019

Quality Payment PROGRAM — Help

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Explore the 4 Phases of Participation

1 Collect — 2 Report — 3 Feedback — 4 Payment

PHASE 2

Report Data

To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology.

Quality Payment PROGRAM — Help

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Explore the 4 Phases of Participation

1 Collect — 2 Report — 3 Feedback — 4 Payment

PHASE 3

Feedback Available

CMS will provide feedback to you on your level of performance and how you compare to historical benchmarks, if applicable.

Quality Payment PROGRAM — Help

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Explore the 4 Phases of Participation

1 Collect — 2 Report — 3 Feedback — 4 Payment

PHASE 4

Payment Adjustment

You may earn a positive MIPS payment adjustment if you submit data by the submission deadline. If you participate in an Advanced APM, then you may earn a 5% incentive payment.

What is the MIPS Performance Period for 2019?

The 2019 MIPS performance period is from January 1, 2019 to December 31, 2019. For the Cost and Quality performance categories, data is collected for the full year. For the Improvement Activities and Promoting Interoperability performance categories, data is collected for at least a continuous 90-day period. If you submit 2019 data for MIPS by March 31, 2020, you'll receive a positive, negative, or neutral payment adjustment in 2021, which will be based on your MIPS final score.

Performance period	Submit	Feedback available	Adjustment
2019 Performance Year	**March 31, 2020*** Data Submission	**July 2020** Feedback	**January 1, 2021** Payment Adjustment
• Performance period opens January 1, 2019 • Closes December 31, 2019 • Clinicians care for patients and record data during the year	• Deadline for submitting data is March 31, 2020 • Clinicians are encouraged to submit data early *Date differs for CMS Web Interface and claims-based data submission	• CMS provides performance feedback after the data is submitted • Clinicians will receive feedback before the start of the payment year	• MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2021

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PY = Performance Year

The cycle of the program looks like this:

PY1   PY2   Adjustment from PY1

± 4%   ± 5%   ± 7%   ± 9%

Adjustment from PY2

2017   2018   2019   2020   2021   2022

PY3 — Adjustment from PY3

Critical Things to Know/Decide/Do…

- 1) Are my future Medicare claims paid via MIPS?
  - Exclusion Criteria?
  - Can I Opt Out?
  - Do I qualify for an Exception?
  - Can I Opt In?
- 2) Will I participate as an INDIVIDUAL, GROUP, or VIRTUAL GROUP?
- 3) Will I report Quality via Claims, EHR, or Registry Reporting?
  - *If EHR/Registry, get your EHR vendor's eCQM report*
- 4) Am I in a "small" or "large" practice?

Need to Know…

1) Are my future Medicare claims paid via MIPS?

YES! All Medicare Providers are by default in MIPS, <u>unless</u> in APMs <u>*or*</u>…

Can I "<u>Opt Out</u>" of MIPS?

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There are 3 groups of clinicians who will NOT be subject to MIPS:

FIRST year of Medicare Part B participation   Below low patient volume threshold   Certain participants in ADVANCED Alternative Payment Models

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Can I "<u>Opt Out</u>" of MIPS?

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There are 3 groups of clinicians who will NOT be subject to MIPS:

FIRST year of Medicare Part B participation   Below low patient volume threshold   Certain participants in ADVANCED Alternative Payment Models

MIPS Exempt _if_ Below Low Volume Threshold (LVT)

- Submit ≤**$90,000** in Medicare-B allowable charges, **OR**
- You see ≤**200** Medicare patients in a year, **OR**
- _**You perform ≤200 covered professional services (refraction not included)**_

  Then no application, no forms, nothing to do!

- Determination periods based on billings from:
  - Oct. 1, 2017 – Sept. 30, 2018 &
  - _Oct. 1, 2018 – Sept. 30, 2019_
    i.e. Prior year and parts of performance year

Low-Volume Threshold Criteria
You are part of the MIPS track of the Quality Payment Program if you:

| Bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS) | and | Furnish covered professional services to more than 200 Medicare beneficiaries a year | and | Provide more than 200 covered professional services under the PFS |

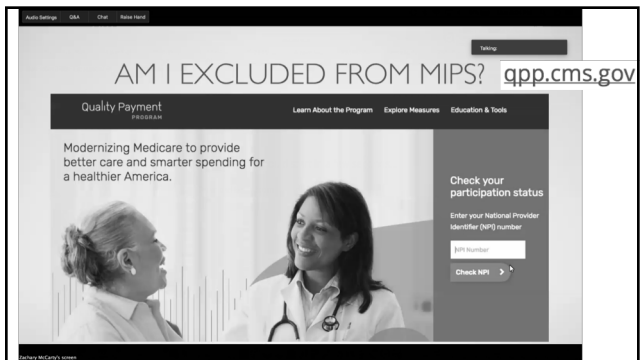
Who is Excluded from MIPS?
If you do not exceed all three above criteria for the 2019 performance year, **you are excluded** from MIPS. However, you have the opportunity to opt-in to MIPS if you meet or exceed one or two, but not all, of the low-volume threshold criteria.

You're also excluded from MIPS in the 2019 performance year if you:

| Enrolled in Medicare for the first time in 2018 | or | Participate in an Advanced APM and are determined to be a Qualifying APM Participant (QP) | or | Participate in an Advanced APM and are determined to be a Partial QP and do not elect to participate in MIPS |

How Do I Check If I am Eligible to Participate in MIPS?
To check if you're eligible to participate in MIPS in 2019, enter your 10-digit National Provider Identifier in the Quality Payment Program Participation Status Tool on the Quality Payment Program website.

AM I EXCLUDED FROM MIPS? qpp.cms.gov

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https://qpp.cms.gov/participation-lookup

QPP Participation Status

Enter your 10-digit National Provider Identifier (NPI) number to view your QPP participation status by performance year (PY).

QPP Participation Status includes APM Participation as well as MIPS Participation.

Please note that the QPP Participation Status Tool is only a technical resource and is not dispositive of any eligible clinician's, group's, or organization's status under QPP. For more information, please refer to the Quality Payment Program regulations at 42 C.F.R. part 414 subpart O.

2018 Participation Status

Mips Not Required, OD
NPI: #0000000000000

Associated Practices (1)

Mips Not Required, OD at **BOND WROTEN EYE CLINIC**

60007 W WAY DR, AMITE, LA 70422-4186

MIPS Eligibility: **INDIVIDUAL** ⊘ GROUP

2018 Participation Status

CHRISTOPHER WROTEN, OD
NPI: #1902919913

Associated Practices (1)

CHRISTOPHER WROTEN at **BOND WROTEN EYE CLINIC** + Expand

60007 W WAY DR, AMITE, LA 70422-4186

MIPS Eligibility: ⊘ INDIVIDUAL ⊘ GROUP

Clinician Level Information

Exceeds low volume threshold	Yes
Medicare patients for this clinician	Exceeds 200
Allowed charges for this clinician	Exceeds $90,000
MIPS eligible clinician type	Yes
Enrolled in Medicare before January 1, 2018	Yes

Practice Level Information

Exceeds low volume threshold	Yes
Medicare patients at this practice	Exceeds 200
Allowed charges at this practice	Exceeds $90,000

Other Reporting Factors

Learn more about how other reporting factors are determined

Clinician Level

SPECIAL STATUS **Health Professional Shortage Area (HPSA)**	Yes
SPECIAL STATUS **Rural**	Yes
SPECIAL STATUS **Small practice**	Yes

Practice Level

SPECIAL STATUS **Health Professional Shortage Area (HPSA)**	Yes
SPECIAL STATUS **Rural**	Yes
SPECIAL STATUS **Small practice**	Yes

Can I *Opt In* to MIPS?

- 2017: No
- 2018: No
- 2019: ??
  - YES!!!
  - If you meet ANY ONE of the LVT Criteria:
    - Risk/Reward is built into the system!
    - If you meet at least 1 but not all of the $90k/200/200
    - LVT ($90/200/200) is likely to change (lower) in future
    - Opt in is desired by many!

I'm under the $90k/200 for Medicare Patients...

...so why should I still pay attention?

- Practice for when LVT is lowered in future!!
  - You can submit 2019 data
    - Get a score
    - Physician Compare website
      - 30 day opt out
    - No payment adjustment
    - Know how good you are
- 2020 rules?

Need to Decide...

2) Will I participate as an INDIVIDUAL, GROUP, or VIRTUAL GROUP?

Recall, Excluded from MIPS in 2019 if:
- Submit ≤**$90,000** in Medicare-B allowable charges, **OR**
- You see ≤**200** Medicare patients in a year, **OR**
- *You perform ≤200 covered professional services (refraction not included)*

Slide 1

Quality Payment
PROGRAM

MIPS ˅   APMs ˅   About ˅
Merit-based Incentive   Alternative Payment   The Quality
Payment System   Models   Payment Program

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Individual or Group Participation

If you're included in MIPS, you'll need to decide whether you will send in MIPS data as an individual or with a group.

Check Your Participation Status ˃

Report as an individual

If you report as an individual, **your payment adjustment will be based on your performance.**

An individual is defined as a single clinician, identified by a single National Provider Identifier (NPI) number tied to a single Tax Identification Number (TIN).

You'll need to send your individual data for each of the MIPS categories through an electronic health record or a registry. You can also send in quality data through your routine Medicare claims process.

Report with a group

Each eligible clinician participating in MIPS via a group will receive a payment adjustment based on the group's performance.

Under MIPS, a group is defined as a single Taxpayer Identification Number (TIN) with 2 or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their National Provider Identifiers (NPI), who have reassigned their Medicare billing rights to the TIN.

For 2017, groups are able to choose from a list of available data

Slide 2

Reporting Options

OPTIONS

Individual	Group	Virtual Group
1. Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits	2. As a Group a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN* b) As an APM Entity	3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year

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* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.

Slide 3

Pick Your Poison

- Submit to CMS as:
  - Individual
  - Group
    - Same TIN
    - No limit on NPIs
  - Virtual Group
    - Considered Small Practice if ≤15 clinicians
    - Considered Rural if >75% of NPIs billing under the Virtual Group's TIN are in rural/HPSA zip code

POISON

Slide 4

CMS   qpp.cms.gov 9

Quality Payment Program

Virtual Group Statutory Provisions

- Virtual Groups will be scored on combined performance (for quality and cost).
- Election:
  - Individual eligible clinicians and small group practices (10 or less eligible clinicians reassigning to the same TIN) may join Virtual Groups.

Slide 5

What is a virtual group?

- A virtual group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year.

To be eligible to join or form a virtual group, you would need to be a:

- **Solo practitioners** who exceed the low-volume threshold individually, and are not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
- **Group** that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

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Slide 6

Virtual Groups (VG)

- At least 1 clinician per TIN must be MIPS eligible (i.e. over $90K/200 pts/200 services) to be in a VG as an individual or group
- MIPS eligible groups can participate in VGs if group is over the $90K/200/200

Slide 1

What else do I need to know?
- Generally, policies that apply to groups would apply to virtual groups.
- Virtual groups use same submission mechanisms as groups.
- **All** clinicians within a TIN are part of the virtual group.
- Virtual groups are required to aggregate their across the virtual group for each performance category and will be assessed and scored as a virtual group.
- If TIN/NPIs is participating in both a virtual group and an APM, such TIN/NPI will receive a final score based on the virtual group performance and a final score based on performance in an APM. However, such TIN/NPI will receive a payment adjustment based on the APM score.

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Slide 2

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How do I make an election?
- Two-stage election process for virtual groups:
  - **Stage 1 (optional):** Solo practitioners or groups with 10 or fewer eligible clinicians can choose to contact their local Quality Payment Program Technical Assistance organization to see if they are eligible to join or form a virtual group. For contact information on your local Technical Assistance organization, please visit qpp.cms.gov.
  - **Stage 2:** For groups that don't participate in stage 1 of the election process and don't ask for an eligibility determination, CMS will see if they're eligible to be in a virtual group during stage 2 of the election process.

Slide 3

Virtual Groups (VG)

- Formal written agreement between TINs
  - Must be finalized before Dec. 1 *of the prior year*
- Official Rep from each TIN must sign

Slide 4

How do I make an election?
- Each virtual group has to:
  1. Have a **written formal agreement** between each of the virtual group members before election.
  2. Name **an official representative** who e-mails the group's election to MIPS_VirtualGroups@cms.hhs.gov
  3. Each virtual group's official representative must e-mail the group's election by **December 31, 2017.**
  4. Virtual group elections have to include at least the information about each TIN and NPI associated with the virtual group and the virtual group representative's contact information. The virtual group representative would need to acknowledge that a written formal agreement has been established between each member of the virtual group prior to election.
- To learn more, see the 2018 Virtual Groups Toolkit.

Slide 5

How to Form a Virtual Group

1. Call your QPP Technical Assistant Rep to set it up; or
2. Or Make a written agreement and email MIPS_VirtualGroups@cms.hhs.gov

Electronic election option in 2019?

Slide 6

Performance Category	Submission Method	
	Individuals	Groups
Quality	• Claims • Electronic Health Record (EHR) (via Health IT Vendor) • Qualified Clinical Data Registry (QCDR) • Qualified Registry	• EHR (via Health IT Vendor) • QCDR • Qualified Registry • CMS-Approved Survey Vendor (for the CAHPS for MIPS Survey) • CMS Web Interface (groups with 25 or more eligible clinicians, including APM Entities (i.e., Accountable Care Organizations (ACOs))
Improvement Activities	• Attestation • EHR (via Health IT Vendor) • QCDR • Qualified Registry	• Attestation • EHR (via Health IT Vendor) • QCDR • Qualified Registry • CMS Web Interface (groups with 25 or more eligible clinicians)
Advancing Care Information Now: Promoting Interoperability (PI)	• Attestation • EHR (via Health IT Vendor) • QCDR • Qualified Registry	• Attestation • EHR (via Health IT Vendor) • QCDR • Qualified Registry • CMS Web Interface (groups with 25 or more clinicians, excluding APM Entities)

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Need to Decide…

3) Will I submit **QUALITY** data by CLAIMS or EHR/Registry?
  • Rule of 60's

> Recall, Excluded from MIPS in 2019 if:
> • Submit ≤**$90,000** in Medicare-B allowable charges, **OR**
> • You see ≤**200** Medicare patients in a year, **OR**
> • *You perform ≤200 covered professional services (refraction not included)*

Why Does It Matter? = The Rule of 60's

• **QUALITY** Component of MIPS
• **60%** of ALL patients
  • For EHR- & Registry-based submission
• **60%** of Medicare patients
  • For Claims-based submission

This is a 2018 & 2019 rule!

Need to Know…

4) Am I in a "Small" or "Large" practice?

  • Ease for *SMALL PRACTICE* comes up several times within MIPS

  • Small Practice =
    • ≤15 CMS clinicians
  • Large Practice =
    • 16+ CMS clinicians

  • Medicare identifies your practice as "small" or not!
    • Automatic-based PECOS registration, zip code, TIN, billing

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Special Status	Component	Year 2 (2018) Final	Application
Small Practice	Definition	• Practices consisting of 15 or fewer eligible clinicians.	• **No change** to the application of these special statuses from Year 1 to Year 2.
Rural and Health Professional Shortage Areas	Rural and HPSA practice designations	• An individual MIPS eligible clinician, a group, or a virtual group with multiple practices under its TIN (or TINs within a virtual group) with **more than 75 percent** of NPIs billing under the individual MIPS eligible clinician or group's TIN or within a virtual group in a ZIP code designated as a rural area or HPSA.	

https://qpp.cms.gov/participation-lookup

MIPS Participation Status

To check if you need to submit data to MIPS, enter your 10-digit National Provider Identifier (NPI) number.

If you're exempt from MIPS with the first review, you won't need to do anything else for MIPS this year. If you are included in MIPS, you may be exempt with the second review of eligibility determinations at the end of 2017. Learn more about MIPS eligibility.

NATIONAL PROVIDER IDENTIFIER (NPI)

117890001   Check Now >

January 1, 2019

Merit-Based Incentive Payment System (MIPS)

Your Performance
- 2017 Performance
- 2018 Performance
- 2019 Performance
- 2020 Performance

Your Payment
- 2019 adjusted Physician Fee Schedule
- 2020 adjusted PFS
- 2021 adjusted PFS
- 2022 adjusted PFS
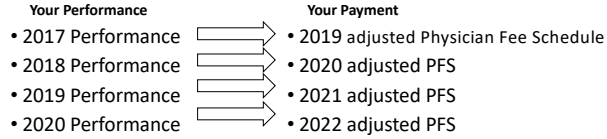
Your 2019 MIPS 0-100 Grade (Score) is Weighted

2018
- **Quality (PQRS): 50%**
- **Advancing Care Info (MU):** 25%
- **Improvement Activities:** 15%
- **Cost: 10%**

2019
- **Quality: 45%**
- **Advancing Care Info:** 25%
- **Improvement Activities:** 15%
- **Cost: 15%**

Unchanged from 2018

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Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Advancing Care Information	90-days

2019 Performance Period

- **Quality: Jan1-Dec31**
- **Advancing Care Info: any 90+ continuous days**
- **Improvement Activities: any 90+ continuous days**
- **Cost: Jan1-Dec31**

YOUR 0-100 MIPS SCORE above TPS **BONUS**

CMS Weighted and Calculated Annual "Threshold Performance Score" (TPS)

YOUR 0-100 MIPS SCORE below **PENALTY**

How much can MIPS adjust payments?

Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024

3X max

Additional Performance Threshold

Additional Performance Threshold

EPs above performance threshold = positive payment adjustment

* +4%	* + 5%	* + 7%	* + 9%

Lowest 25% = maximum reduction

-4%	-5%	-7%	-9%
2017	2018	2019	2020

Performance Threshold

Performance Years

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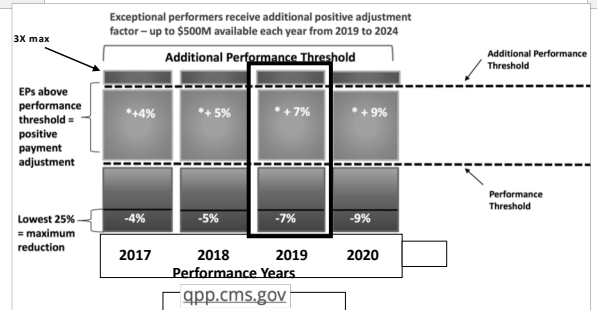
Final MIPS SCORE Above the Curve for 2019

- **30%** (aka 30 points) is the curve in 2019
  - No pay reduction!
- The curve changes every year...
  - = 3 in 2017
  - = 15 in 2018
  - = **30 in 2019**
  - = Mean/Median of all **MIPS SCORES** for 2022?

UNITED STATES	
PERCENTAGE	LETTER GRADE
90-100%	A
80-89%	B
70-79%	C
60-69%	D
0-59%	F
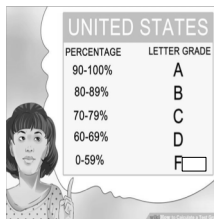
MIPS Scores from Performance Year 1 (2017)

	Mean	Median
• Overall	**74**	**89**
• Individual/Group*	65	83
• Large Practice	74	90
• Small Practice	43	37
• Rural Practice	63	75

Recall Performance Threshold was 3   *Not including APM

MIPS Scores from Performance Year 1 (2017)

MIPS Eligible Clinicians:
- 5% received Negative Pay Adjustment (4% penalty for scores 0-2.99)
- 2% received Neutral Pay Adjustment (score=3.0)
- 22% received Basic Positive Pay Adjustment (≤0.20% bonus for scores of 3.1-69.99)
- 71% received Exceptional Bonus Pay Adjustment (≤1.88% bonus for scores of 70-100)

Small Practice Performance:
19% Penalty, 30% Basic Bonus, 44% Exceptional Bonus

How much can MIPS adjust payments?

Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024

3X max

Additional Performance Threshold

EPs above performance threshold = positive payment adjustment

| *+4% | *+ 5% | * + 7% | * + 9% |

Additional Performance Threshold **75 points**

Performance Threshold **30 points**

Lowest 25% = maximum reduction

| -4% | -5% | -7% | -9% |
| 2017 | 2018 | 2019 | 2020 |

Performance Years

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Minimum?

- Don't set out to be The Minimum
  - Mild effort can get you above **30%** in 2019
    - Especially if you are in Small Practice!
    - Avoids negative pay adjustment
- Difficulty increases in 2020 & beyond

COLLEGE

MIPS Payments for ODs

- **Quality**
- **Promoting Interoperability**
- **Cost**
- **Improvement Activities**

MIPS Cheat Sheet

- **Quality**
  - **5-1-Done!**
- **Promoting Interoperability**

- **Cost**
  - **Something! Nothing!**
- **Improvement Activities**
  - **New, 1!**

MIPS Payments for ODs

- **Quality**
- Promoting Interoperability
- Cost
- Improvement Activities

"Quality" is Still Driven by PQRS Ideology

- PQRS
- 2007
  - Voluntary/<u>bonus</u>
- 2013
  - <u>Penalty</u> for not participating (2015 Fee Schedule)

Carry the Optometry Torch!!!

Claims-Based PQRS Reporting

- Adding additional codes to our claims
- Does not work well
- Need for change
  - Start using EHR/Registry to report!!!!
- #ClaimsBasedSux
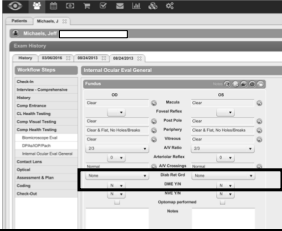
Correlating Your EHR Exam to QUALITY Measures

- electronic Clinical Quality Measures (eCQM)
  - Matches your EHR data field to appropriate Quality code
    - If you click the correct boxes then a correlating **QUALITY** (PQRS) Code applies

Get Your eCQM Report from your EHR vendor

Surviving Quality Measures with eCQMs!
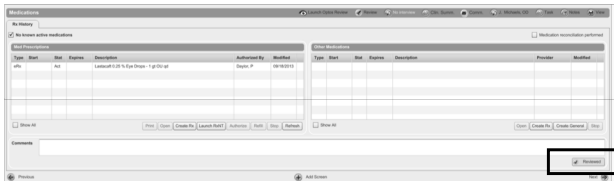
- Example
  - Diabetes Eye Exam (no Retinopathy)
    - Age 18-75
    - 99xxx or 92xxx
    - **Diabetes Diagnosis**
    - Retina findings documented
      - No Retinopathy

Quality Measure: POAG (Document ONH)
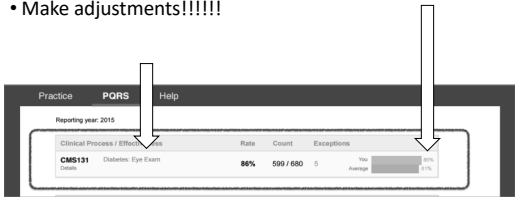
Quality Measure: Documentation of Current Meds

What If I'm Below 60%?

- Make adjustments!!!!!!

Quality 5-1-Done! Cheat Sheet

- DM eye exam (no retinopathy)*
- ~~Diabetic Retinopathy~~
- Diabetic Ret letter to PCP[!]
- POAG*
- AMD exam*
- ~~AMD AREDS counseling~~

- ☐ ≥6 measures (1 outcome/high priority)
- ☐ Earn 0-10 pts for each
- ☐ Need ≥20 Patients
- ☐ ≥60% of time for full credit
- ☐ Submission method matters

- Document meds[!]*
- BMI measure
- BP Screening
- Close the referral loop[!]
- Tobacco Screening/Cessation*
- POAG 15% reduction[!!]
- BP control[!!]
- A1c control[!!]

* Top 5 submitted in 2015 by ODs
! High priority, get bonus point
Double bonus if 2nd Outcome measure

Rules for Picking QUALITY Measures in Your Practice

- Maximizing your score per QUALITY measure
  - Do I have enough patients with this disease?
    - **20+ patients per QUALITY measure**
    - E.g., 20+ glaucoma patients per year
  - Is the **QUALITY** measure new this year?
    - Most eye care measures are not new this year
  - Is the **QUALITY** measure "topped out"?
    - Everyone performs the task at a super high level
  - Did I perform the task enough?
    - I have to perform the task **60% of the time** or more

Topped Out

- "Performance so high and unvarying that meaningful distinctions & improvements in performance can no longer be made"
  - Everyone is performing the **QUALITY** measure at a very high level.
  - Varies based on how you submit data to CMS
- Remember why PQRS started!
- Topped out varies based on data submission method
- E.g., Document ONH for POAG patients
  - Claims-based: Topped out
  - EHR/AOA MORE: <u>Not</u> topped out

Be Careful Selecting Your QUALITY Measures

**Topped Out Quality Measure:
Median Performance Rate of 95% or Higher**

Decile Breaks for a Quality Measure

DECILE	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
POINTS	1.0-1.9	2.0-2.9	3.0-3.9	4.0-4.9	5.0-5.9		7 points			

0%   75%   80%   85%   95%   100%

cms.gov

Topped Out Life Cycle for <u>Eye Care Measures</u>

- Specific eye care measures
- Jan 2018: Identified as "topped out"...NO PENALTY FOR 2018!
- Jan 2019: if you use these "topped out" **QUALITY** measures, the maximum score you will get is <u>7 points per measure (instead of 10)</u>
- Jan 2020: same as 2019
- Jan 2021: they are no longer available to be used
  - Will have to find other **QUALITY** measures

1st Year Topped Out in 2018
Still safe to use in 2019, except…

Claims
- DM Exam
- DM letter to PCP
- AMD
- ~~AMD AREDS~~
- POAG
- POAG15%
- Document Current Meds
- Smoking Assessment

EHR/AOA MORE
- DM Exam
- Document Current Meds

Quality 5-1-Done! Cheat Sheet

- DM eye exam (no retinopathy)*
- ~~Diabetic Retinopathy~~
- Diabetic Ret letter to PCP[!]
- POAG*
- AMD exam*
- ~~AMD AREDS counseling~~

- ☐ ≥6 measures (1 outcome/high priority)
- ☐ Earn 0-10 pts for each
- ☐ Need ≥20 Patients
- ☐ ≥60% of time for full credit
- ☐ Submission method matters

- Document meds[!*]
- BMI measure
- BP Screening
- Close the referral loop[!]
- Tobacco Screening/Cessation*
- POAG 15% reduction[!!]
- BP control[!!]
- A1c control[!!]

*** Top 5 submitted in 2015 by ODs
! High priority, get bonus point
Double bonus if 2nd Outcome measure**

14

Quality 5-1-Done! Cheat Sheet

High Priority Measures
Outcomes Measures

- DM eye exam (no retinopathy)*
- **Diabetic Ret letter to PCP[!]**
- POAG*
- AMD exam*

- **Document meds[!]***
- BMI measure
- BP Screening
- **Close the referral loop[!]**
- Tobacco Screening/Cessation*
- **POAG 15% reduction[!!]**
- **BP control[!!]**
- **A1c control[!!]**

Know the QUALITY 5-1-Done!

You must have:
- **6 Quality Measures**
  - 1: "**Outcomes**" measure
    - 1 **"High Priority"** measure if no **"Outcomes"** measure available
  - 5: Any measures

Quality 5-1-Done! Cheat Sheet

- DM eye exam (no retinopathy)*
- Diabetic Ret letter to PCP[!]
- POAG*
- AMD exam*

- Document meds[!]*
- BMI measure
- BP Screening
- Close the referral loop[!]
- Tobacco Screening/Cessation*
- **POAG 15% reduction[!!]**
- **BP control[!!]**
- **A1c control[!!]** } PICK 1 OUTCOME

Quality 5-1-Done! Cheat Sheet

- DM eye exam (no retinopathy)*
- **Diabetic Ret letter to PCP[!]**
- POAG*
- AMD exam*

- **Document meds[!]***
- BMI measure
- BP Screening
- **Close the referral loop[!]** } PICK 1 HIGH PRIORITY
- Tobacco Screening/Cessation*
- ~~POAG 15% reduction[!!]~~
- ~~BP control[!!]~~
- ~~A1c control[!!]~~ } PICK 1 OUTCOME

Quality 5-1-Done! Cheat Sheet

- DM eye exam (no retinopathy)*
- **Diabetic Ret letter to PCP[!]**
- POAG*
- AMD exam*

- **Document meds[!]***
- BMI measure
- BP Screening
- **Close the referral loop[!]**
- Tobacco Screening/Cessation*
- **POAG 15% reduction[!!]**
- **BP control[!!]**
- **A1c control[!!]** } PICK ANY OTHER 5

* Top 5 submitted in 2014 by ODs
! High priority, get bonus point
Double bonus if 2nd Outcome measure

AOA More / AOA Member Resources

Recommended Quality Measures to Report & their status

Measure	CMS Number	Type	Recommended Reporting Method(s)	Topped Out
Controlling High Blood Pressure	CMS165v5 / 236	Outcome Measure	AOA MORE/EHR	NO
Diabetes: Hemoglobin A1c Poor Control	CMS122v5 / 1	Outcome Measure	AOA MORE/EHR	NO
Documentation of Current Medication	CMS68v6 / 130	High Priority Measure	AOA MORE/EHR → Claims	YES (7 point cap for AOA MORE and claims)
Closing the Referral Loop: Receipt Measure of Specialist Report	CMS50v5 / 374	High Priority Measure	AOA MORE/EHR	NO
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	CMS142v5 / 19	High Priority Measure	AOA MORE/EHR → Claims →	NO (not topped out for AOA MORE) / YES (7 point cap for claims)
Diabetes: Eye Exam	CMS131v5 / 117	Process Measure	AOA MORE/EHR Claims	NO (not topped out for AOA MORE) / YES (7 point cap for claims)
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	CMS143v5 / 12	Process Measure	AOA MORE/EHR Claims	NO (not topped out for AOA MORE) / YES (7 point cap for claims)
Preventive Care and Screening: Tobacco Use	CMS138v5 /226	Process Measure	AOA MORE/EHR Claims	3 point cap for claims and AOA MORE
Age-Related Macular Degeneration: 14 Dilated Macular Examination	14	Process Measure	Claims	YES (7 point cap for claims)
Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% OR Documentation of a Plan of Care	141	Outcome Measure	Claims	YES (7 point cap for claims)

Quality 5-1-Done!

- Make sure your EHR can count the **Quality** Measures you select!

MIPS "Quality" Pick 6

- You can <u>pick more</u> than 6
  - CMS takes the 6 that give you the highest overall score!

Go for MIPS Bonuses in QUALITY Measures!!!

- **High Priority Bonus**
  - Includes **Outcome** & **High Priority**
- **End-to-End Points**
- **Improvement % Score**

High Priority Bonus in QUALITY Measures!!!

- Applies after the mandatory first **Outcome** or **High Priority**
  - Additional **Outcome** measures: 2 points per measure
  - Additional **High Priority** measures: 1 point per measure
- Maximum bonus for **Outcome** and **High Priority** is 6 points to your **QUALITY** Achievement Points

Quality 5-1-Done! Cheat Sheet

- DM eye exam (no retinopathy)*	- **Document meds!***
- **Diabetic Ret letter to PCP!**	- BMI measure
- POAG*	- BP Screening
- AMD exam*	- **Close the referral loop!**
	- Tobacco Screening/Cessation*
	- **POAG 15% reduction!!**
	- **BP control!!**
	- **A1c control!!**

* Top 5 submitted in 2015 by ODs
! High priority, get bonus point
Double bonus if 2nd Outcome measure

End-to-End Bonus in Quality Measures!!!

- Electronic submission of **QUALITY** measures (EHR or Registry) direct from your EHR/AOA MORE to CMS
- 1 point per measure
  - Almost all of the EHR/registry submitted measures
  - Not available for Claims-based!
- Maximum bonus for **End-to-End** is 6 points to the **QUALITY** Achievement Points

3/23/19

Improvement % Score

- Year over year improvement in **QUALITY** Achievement Points
  - Per clinician
- Maximum is 10% per clinician
- Gets added to your Achievement/Bonus Points
- Achievement points example…

Be Minimum in 2018?

Avoiding the penalty:
- Is harder than 2017 (& harder in '20?)
- Small Practice:
  - Submit 6 **QUALITY** Codes during the reporting period
    - How well & how often I do will not matter (to be min)

Be Minimum in 2018?

Avoiding the penalty:
- Is harder than 2017 (& harder in '20?)
- Large Practice:
  - Submit 6 different **QUALITY** Codes during the reporting period
  - Must achieve 60% Performance on each measure!
  - How many pts won't matter if do task 60% of time
  - Ex. POAG/LTG Patients
    - if saw 10 POAG/LTG patients in 2018, at least 60% of them must have documented ONH

Be Minimum in 2019?

- Remember, if don't qualify for any Cost assesments (most ODs won't), that 15% is weighted to Quality, too, increasing it's weight to 60% of MIPS score
- Also, note can get half your needed MIPS score just by using easy **Improvement Activities!!**

Submitting QUALITY to CMS

- Claims
  - Like PQRS from the past—add codes to M'care claims as you bill
- EHR
  - Run quality measures report in your EHR
  - Submit xml report through QPP portal
    - Requires EIDM log in credentials
  - This option already exists
- **AOA MORE**
  - **DOESN'T** require pesky CMS web portal log in!!!
- Remember, cannot submit EHR/Registry until **Jan-Mar 2020**

Quality <u>Scoring</u> Rules for 2018

- 6 measures
- 0-10 Achievement Pts per measure (Goal: 60 tot. Achievement Pts for **QUALITY**)
- Get 1-2 bonus pts for extra **High Priority, Outcomes** and **End-to-End** measures
  - Then add the overall **Improvement %**

*3 points for Small practice,
1 point for Large practice

MIPS Payments for ODs

- Quality
- **Promoting Interoperability**
- Cost
- Improvement Activities

MIPS Cheat Sheet

- **Quality**
  - **5-1-Done!**
- **Promoting Interoperability**

- **Cost**
  - **Something! Nothing!**
- **Improvement Activities**
  - **New, 1!**

Promoting Interoperability (PI)
{formerly Advancing Care Information}

- Think Meaningful Use (MU)

  - Grades provider from 0-100
  - 4 performance categories
    - Quality (45% of grade)
    - **Advancing Care Info (25% of grade)**
    - Cost(15% of grade)
    - Improvement Activities (15%)

Promoting Interoperability (PI)

- Is your EHR Stage 2 compliant or Stage 3 compliant?
  - 2014 certified (Modified Stage 2)
  - 2015 certified (Stage 3)
    - ***** Required starting Jan 1, 2019 *****

Promoting Interoperability (PI)

2014 Edition	**2015 Edition**
• Modified Stage 2	• Stage 3
• **PI** Transition Objectives & Measures	• **Mandated by Jan 1, 2019**
	• **PI** Objectives & Measures

Promoting Interoperability (PI)

- 2015 Edition
- Stage 3
- **PI** Objectives & Measures

Promoting Interoperability(PI)

- Old:
  - ~~Base Score~~
  - ~~Performance Score~~
  - ~~Bonus Score~~
- **New:**
  - **eRx**
  - **Health Information Exchange (HIE)**
  - **Provider to Patient Exchange**
  - **Public Health & Clinical Data Exchange**

Promoting Interoperability(PI)

- **Must do Security Risk Analysis (but no longer get points for it)**

Promoting Interoperability(PI)

- Must report some measures from each objective
- Now performance-based scoring @ measure level
- Failure to report a required measure (or "no" on "yes"/"no" measure unless exclusion = total PI score of ZERO)

Objectives	Measures	Exclusion	Maximum Points
e- Prescribing	e-Prescribing *Bonus*: Query of Prescription Drug Monitoring Program (PDMP) 5 point bonus -Your EHR must be integrated with state PDMP -Requires one prescription for a schedule II medicine. Use clinical judgment and do not issue a prescription solely for the purpose of obtaining a bonus	If you write fewer than 100 permissible prescriptions during the performance period.	10 points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	If you transfer a patient to another setting or refer a patient fewer than 100 times during the performance period.	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	If you are unable to implement the measure for a MIPS performance period in 2019 would be excluded from having to report this measure. Or if you receive fewer than 100 transitions of care or referrals or have fewer than 100 encounters with patients never before encountered during the performance period.	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information "Through EHR online portal"		40 points
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: • Immunization Registry Reporting** • Electronic Case Reporting** • Public Health Registry Reporting** • Clinical Data Registry Reporting** • Syndromic Surveillance Reporting** You can register for AOA MORE as your "Clinical Data Registry." If another registry is available to you (e.g. state syndromic surveillance) you may register for that registry as your second registry. If no additional registry is available to able from AOA MORE, you may claim an exclusion for the second required registry. AOA Members can register for AOA MORE and receive MIPS credit, even if their EHR is not yet integrated.	For these measures you may claim an exclusion if you don't administer vaccinations; or if there is no registry available to accept data at start of the reporting period, OR if there is no registry that has declared readiness to accept data six months prior to the reporting period.	10 points

www.aoa.org

Promoting Interoperability(PI)

www.aoa.org

CHANGES FOR 2019
Removed measures
- Patient-Specific Education
- Secure Messaging
- View, Download or Transmit
- Patient-Generated Health Data

New measures
- Query of Prescription Drug Monitoring Program (PDMP) (bonus)
- Verify Opioid Treatment Agreement (bonus)
- Support Electronic Referral Loops – Receiving and Incorporating Health Information

Security Risk Analysis (SRA) Change!
- **Security Risk Analysis requirement is retained for 2019, but will not be scored. Do not complete your SRA until you are using 2015 certified (stage 3) EHR**

Submitting PI Measures to CMS

- Like submitting for Meaningful Use
  - Run reports from your EHR
  - Submit data on QPP portal

MIPS Payments for ODs

- Quality
- Advancing Care Info
- **Cost**
- Clinical Practice Activities

MIPS Cheat Sheet

- **Quality**
  - **5-1-Done!**
- **Promoting Interoperability**

- **Cost**
  - **Something! Nothing!**
- **Improvement Activities**
  - **New, 1!**

"Cost" for MIPS

- Something is being collected by CMS
- **Nothing to submit by doctor**
- Math done by CMS
  - Per Capita expenses
  - Medicare Spending per Beneficiary
- Working to create episode-based measures
  - e.g. Diabetes, cataract surgery w/ co-mgt
- Based on 12 months

Cost & Value

- **Cost** was removed from MIPS calculation in 2017
- **Cost** will be 10% of the total MIPS score in 2018
- **Cost** will be 15% of the total MIPS score in 2019
- MIPS legislation
  - For every % **Cost** goes up, **QUALITY** goes down same %
- Re-weighting
  - Re-weight this 15% to **QUALITY** if not enough **Cost** data for you
  - Likely for many ODs
  - If so, QUALITY goes up to 60% your final **MIPS SCORE**

Get Your Quality and Resource Use Report (QRUR)

- To be replaced by MIPS Feedback Report

MIPS Payments for ODs

- Quality
- Promoting Interoperability
- Cost
- **Improvement Activities**

MIPS Cheat Sheet

- **Quality**
  - **5-1-Done!**
- **Promoting Interoperability**

- **Cost**
  - **Something! Nothing!**
- **Improvement Activities**
  - **New, 1!**
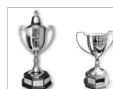
Improvement Activities (IA) {formerly CPIA}

- New to the Quality Payment Program in 2017
  - Activities in your practice that help the public
  - *Think of as your role in Public Health*
- Added new **IAs** in 2019, including one for eye care (thanks AOA!)
  - **Promoting Eye Exams**
    - MIPS-eligible clinicians must provide literature or facilitate conversations about the topic "using resources such as the Think About Your Eyes campaign, and/or referring patients to resources providing no-cost eye exams ... such as the American Optometric Association's VISION USA"
    - For 2019, any doctor type who educates patients on the value of comprehensive eye exams can earn this MIPS improvement activity credit

Improvement Activities (IA)

- You need 40 points for max **IA** score
  - 10 point measures ("Medium Weight")
  - 20 point measures ("High Weight")
  - Points doubled for "small practices"
    - May be able to achieve 40 points with "1" measure
- Select measures to reach 40 total points
- Heavily weighted to those using specific clinical registries
  - Qualified Clinical Data Registry (QCDR)
    - **AOA MORE**

Pick Your IA Path

- Are you a "Small" practice or a "Large" practice?
- Your CPIA requirements depend on how big your practice is
  - By Tax ID#
  - "Small" Practice vs "Large" Practice
    - "Small" offices will have advantages

Pick Your IA Path (by TIN)

- "Small Office"
  - 15 or fewer CMS clinicians
  - Rural Area
  - Health Professional Shortage Area
- All activities are double points!

- "Large Office"
  - >15 CMS clinicians
- Pick any combo to make 40 points
  - Each is worth 10, 20 points

PICK 1-4 TO ADD TO 40 POINTS

Small Office=DOUBLE POINTS TO ADD TO 40 POINTS
Large Office=PICK 1-4 TO ADD TO 40 POINTS

High Weight (20 points each)

- Use **AOA MORE** to report local practice patterns
- **24/7 access to clinicians****
- Consult state PDMP for SchII lasting longer than 3 days
  - Prescription Drug Monitoring Program

Medium Weight (10 points each)

- Use **AOA MORE** to show outcome comparisons across specific population
- Use **AOA MORE** to promote standard practice uses
- Use **AOA MORE** to track patient safety (microbial keratitis)
- Promoting Eye Exams
- **Close referral loop****: provide reports to referred from physicians
- Engage patients/families in decision making

Being Minimum in 2019 with IA?

- If you maximize your **IA**, you can meet half of your minimum threshold score to avoid a penalty for 2019
- **Improvement Activities** are 15% your total **MIPS SCORE**
  - 15 is also half of the score required to achieve no pay penalty
  - 2019 only
  - AOA MORE for non-EHR users?

AOA MORE Supports the following **IAs**. You can also use AOA MORE to report completion of all other CMS approved improvement activities during the attestation process.

Activity	CMS Reference Number	Weight	Additional Guidance For Meeting IA Reporting Requirements
Participation in a Qualified Clinical Data Registry (QCDR) (AOA MORE), that promotes use of patient engagement tools.	CMS Reference Number IA_BE_7	Medium weight	Login to AOA MORE to obtain and review patient engagement tools. An email will be sent from AOA when new tools are made available. Retain this email for documentation along with the date you accessed materials.
Participation in a QCDR (AOA MORE), that promotes collaborative learning network opportunities that are interactive.	CMS Reference Number IA_BE_8	Medium weight	AOA MORE has access to links to online learning opportunities. Access these resources throughout the year and document your participation in any online learning programs.
Participation in a QCDR (AOA MORE) for quality improvement.	CMS Reference Number IA_PM_10	Medium weight	Check your progress on quality measures throughout the year and review AOA guidance on how to improve your quality scores. Document your efforts to improve as necessary.

Submitting IA Measures to CMS

- <u>Attestation</u> in 2018: only one method can be used!
  - For 2019 performance, you can submit by >1 method
- CMS Web portal (requires EIDM log in)
  - Submit yes/no to any **IAs**
  - No additional data to submit
- **AOA MORE**
  - Submit yes/no to any **IAs**
- EHR
  - Submit yes/no to an **IA**
  - *If your EHR can*

Submitting IA Measures to CMS

- You need to know:
  - What activities did you do?
  - Do you get to double your points per activity (small business)
  - Did you get to 40 points?
  - Print your activities!!!
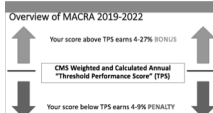   - Audit insurance

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MIPS Cheat Sheet

- **Quality**
  - **5-1-Done!**
- **Promoting Interop**

MIPS Final Score

- **Improvement Activities**
  - **New,1!**

Pay Raise or Pay Cut?

- **MIPS Final Score (0-100) =**
  Quality Score + Advancing Information Score + Improvement Activities + Cost Score
- Small Practice Bonus added to **MIPS Quality Score:** <u>6</u> pts
- Complex Patient Bonus added to **MIPS Final Score:** <u>max 5</u> pts
- *Annual* Threshold Performance Score (TPS)
  - It's *"the curve"*
  - Becomes Mean or Median in future*
    - *Feb. 2018 govt financing bill loosens requirements for 1st 5 yrs of transition

Overview of MACRA 2019-2022

Your score above TPS earns 4-27% BONUS

CMS Weighted and Calculated Annual "Threshold Performance Score" (TPS)

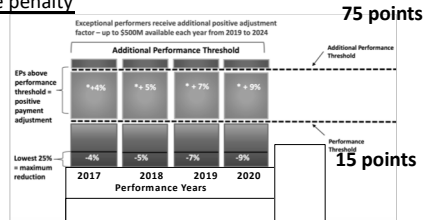Your score below TPS earns 4-9% PENALTY

Re-weighting

- If you are excluded from **PI**
  - Your 25% moves to **QUALITY**
- If you are excluded from **IA**
  - Your 15% moves to **QUALITY**
- If you do not have enough data for **COST**
  - Your 15% moves to **QUALITY**
- If you do not submit **QUALITY**
  - You're SOL!!!

Why is My Penalty >7%

- Scaling Factor for budget neutrality
  - Can add more bonus
  - Can add more penalty

75 points

Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024

Additional Performance Threshold

EPs above performance threshold = positive payment adjustment

| *+4% | *+5% | *+7% | *+9% |

Lowest 25% = maximum reduction

| -4% | -5% | -7% | -9% |

| 2017 | 2018 | 2019 | 2020 |
Performance Years

Additional Performance Threshold

Performance Threshold

15 points

PI Hardship Exemption

- **E.g. Limited internet access in rural area, small practice, etc.**
- *Different from Extreme & Uncontrollable Circumstance Policy*
- There is an **application process**!
- Only applies to **PI**
  - Reweights your **PI** to zero
    - Moves **PI** 25% to **QUALITY**

Performance Category	Submission Method	
	Individuals	**Groups**
Quality	• Claims • Electronic Health Record (EHR) (via Health IT Vendor) • Qualified Clinical Data Registry (QCDR) • Qualified Registry	• EHR (via Health IT Vendor) • QCDR • Qualified Registry • CMS-Approved Survey Vendor (for the CAHPS for MIPS Survey) • CMS Web Interface (groups with 25 or more eligible clinicians, including APM Entities (i.e., Accountable Care Organizations (ACOs))
Improvement Activities	• Attestation • EHR (via Health IT Vendor) • QCDR • Qualified Registry	• Attestation • EHR (via Health IT Vendor) • QCDR • Qualified Registry • CMS Web Interface (groups with 25 or more eligible clinicians)
Advancing Care Information **Now: Promoting Interoperability (PI)**	• Attestation • EHR (via Health IT Vendor) • QCDR • Qualified Registry	• Attestation • EHR (via Health IT Vendor) • QCDR • Qualified Registry • CMS Web Interface (groups with 25 or more clinicians, excluding APM Entities)

qpp.cms.gov

AOA MORE
MEASURES AND OUTCOMES REGISTRY FOR EYECARE
BY PROMETHEUS | RESEARCH

- Database
  - Systematic collection of data
  - Captures data that can be analyzed
    - Analyze to improve care and outcomes
- Qualified Clinical Data Registry**
- Cancer registry...

AOA MORE
MEASURES AND OUTCOMES REGISTRY FOR EYECARE

- Clinical Feedback
  - Glaucoma/Glaucoma Suspect (VF, OCT)
  - Laser Outcomes
  - **QUALITY** measure satisfaction rate
  - Medication Rx's
  - ICD codes
  - Constantly evolving

AOA MORE
MEASURES AND OUTCOMES REGISTRY FOR EYECARE
BY PROMETHEUS | RESEARCH

- Answering Optometry's Questions:
  - Kids under 5?
  - Most common K ulcer?
  - Diabetics?
  - Myopia Progression
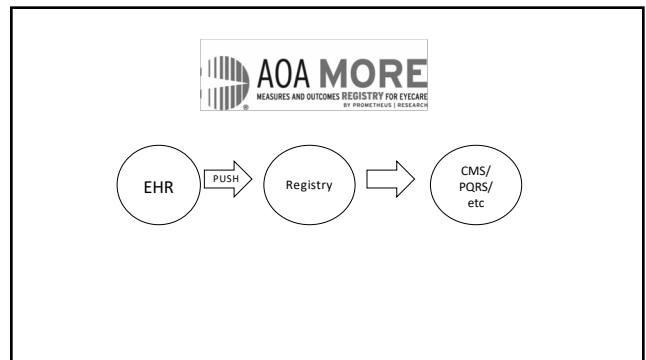- Optometry advocating for Optometry!!
- 30,000+ ODs working together

- Your cost to use AOA MORE?
  - You **DESERVE** to be at the value-based purchasing table
  - $0 to members
    - Registries cost upwards of $100 per month per doctor

- QUESTION:
  - Am I automatically enrolled if my vendor is integrated?
  - No. You must sign up to authorize your data integration
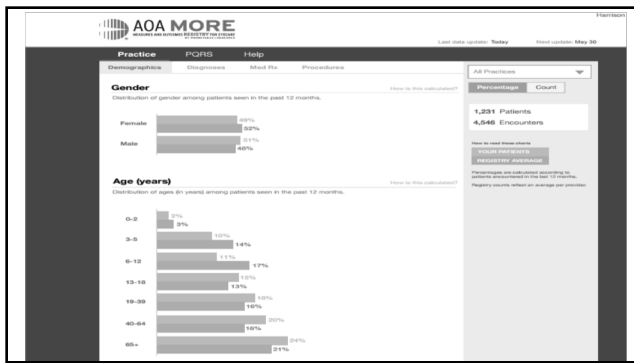   - Register at aoa.org/MORE

AOA MORE
MEASURES AND OUTCOMES REGISTRY FOR EYECARE
BY PROMETHEUS | RESEARCH

- QUESTION:
  What part(s) of MIPS will AOA MORE help me with?
  - **Quality**
    - **Building in 9-12 measures**
    - **Submits directly to CMS**
  - **Promoting Interoperability**
    - **Performance Points but does not submit data**
  - **Improvement Activities**
    - **AOA MORE activities are reported "yes"/"no" by you**
    - **Submits directly to CMS**
    - **Non-EHR users may satisfy 2018 MIPS (avoid penalty) by using AOA MORE for IAs**

AOA MORE
MEASURES AND OUTCOMES REGISTRY FOR EYECARE
BY PROMETHEUS | RESEARCH

Dashboard Screenshots

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MIPS: A ROAD MAP TO SUCCESS

Slide 1

Support for Small Practices

Small practices with 15 or fewer clinicians, including those in rural locations, health professional shortage areas, and medically underserved areas are a crucial part of the health care system. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provides direct technical assistance to help individual Merit-based Incentive Payment System (MIPS) eligible clinicians and small practices in these settings participate in the Quality Payment Program.

This initiative is comprised of local, experienced organizations that will help clinicians in small and rural practices:
- Select and report on appropriate measures and activities to satisfy the requirements of each performance category* under MIPS
- Engage in continuous quality improvement
- Optimize their health information technology (HIT)
- Evaluate their options for joining an Advanced Alternative Payment Model (APM)

Providing this support to clinicians will help them navigate the Quality Payment Program, while making sure they are able to focus on the needs of their patients.

*Quality, Cost, Improvement Activities, and Advancing Care Information

Participating Organizations

Source: cms.gov

Slide 2

Source: cms.gov

STATE / TERRITORY

Florida

Alliant GMCF

QPPSURS@alliantquality.org

Virgin Islands
D.C.
Puerto Rico

Quality Payment Program:
qpp.cms.gov
1-866-288-8292
TTY: 1-877-715-6222
QPP@cms.hhs.gov

Resources

- Healthcentric Advisors
- IPRO
- Quality Insights (WVMI)
- Alliant GMCF
- QSource
- Altarum
- TMF
- HSAG
- Telligen
- NRHI
- Qualis

Slide 3

qpp.cms.gov

PERFORMANCE YEAR 2017

QPP Performance Feedback Is Available

Sign in to view your final performance feedback, which includes your final score and payment adjustment information.

Sign In ›

PERFORMANCE YEAR 2018
Use our updated explore measures tool to see all PY 2018 measures.

Slide 4

qpp.cms.gov

PDF

EIDM Account Guide

Slide 5

Total Clinicians: 1
Reported as: Group & Individual

The Final Score At A Glance

The Final Score is achieved by adding the points you earned in each Performance Category

FINAL SCORE
100 out of 100

Performance Category Scores
- Quality — 60 of 60
- Advancing Care Information — 25 of 25
- Improvement Activities — 15 of 15

Payment Adjustment +2.02%
January 1, 2019

- **Why not +4%?!?!?**
- **Does not include superbonus $$**

Performance Category Overview

Slide 6

"Don't let what you cannot do interfere with what you *can* do. "
- John Wooden

Thank You!

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