Value-Based Reporting for Practices with CMS, Commercial Payers, and Self-Insured Employers

Ensuring Readiness Now and in the Future

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Introduction

The move from fee-for-service to value-based contracting or reimbursement is creating havoc for medical providers throughout the U.S. The programs are complicated to understand and require delivery of data that is difficult to generate, given the limited flexibility within legacy electronic medical record (EMR)/practice management systems.

Sharecare offers a unique consulting and reporting service that 1) Guides you through the measure selection, 2) Connects to your current technology and provides value-based ready data storage and metrics development, and 3) Provides the required information to the payor (e.g., CMS, commercial payors) per their requirements — all without having to invest in new practice technology.

Value-based care is here to stay and will continue to evolve over the coming years. Flexible and fluid technology is essential to meet its demands. This white paper covers value-based care, the administrative burden it places on medical providers, and how quality managers can meet reporting requirements more efficiently and at a lower cost to their practice.

What Is Value-Based Reporting?

Before we explore value-based reporting, what do we mean by "value?" In healthcare, value refers to "health outcomes achieved per dollar spent."[1] Achieving higher value is the shared goal among all stakeholders, including patients, practices, and health insurance companies. Increasing value requires focusing on patients and their outcomes, and maintaining that focus requires a disciplined, exact measurement of value.

This is where value-based reporting comes in. If the focus is increasing value, then one must measure value. The basic value formula, although complicated in practice, can be simplified as follows:

$$\text{Value} = \frac{\text{outcomes}}{\text{cost}}$$

Cost refers to the total cost of the services delivered to the patient for an entire episode of care, not the cost of individual services, i.e., fee-for-service. The fact that outcomes are part of the value equation highlights that results are measured by patient outcomes — not by the process of care used, i.e., which tests, surgeries, and medications were used. That is, the process is no longer fee-for-service but value-based.

Why Does Value-Based Reporting Matter for Medicare Providers?

For independent group practices with providers that bill at least $200,000, treat at least 200 Medicare patients, and furnish more than 200 services, fulfilling value-based reporting requirements correctly is critical for two reasons. Firstly, value-based reporting is essential to value-based care, and value-based care improves patient outcomes. For example, one practice's three-year foray into value-based care resulted in "a 60% reduction of asthma-related ER visits, a 44% reduction in asthma-related hospital admissions, and more than a $2,100 reduction in annual medical costs per child."[2]

Secondly, receiving Medicare reimbursements depends on correctly performed value-based reporting based on factual data and relevant measures. In the history of the Medicare reimbursement system since the Tax Relief and Health Care Act of 2006, the Physician Quality Reporting Initiative evolved into the Physician Quality Reporting System, which in turn evolved into the Merit-Based Incentive Payment System (MIPS). MIPS is the value-based reporting process that many practices find themselves knee-deep in today, and the reporting requirements are growing ever more stringent.

What Is CMS MIPS?

MIPS is a required reporting program for all eligible clinicians who do not participate in another value-based care contracting program, such as accountable care organizations (ACOs) or bundle payments. There are three reporting options for MIPS:

1. Traditional MIPS
2. MIPS Value Pathway (MVPs)
3. APM Performance Pathway (APP)

Each reporting option measures the following four performance categories:[3]

1. **Quality:** the quality of patient care as defined by CMS and supported by choosing at least six quality measures within the MIPS program
2. **Promoting interoperability:** the use of electronic health records to improve the exchange of health information and patients' access to their health data
3. **Improvement activities:** a practice's improvements in care, patient engagement, and access to care
4. **Cost:** the cost of care a practice provides

The Challenges of MIPS

MIPS reporting can be highly confusing for clinical administrators. It isn't easy to understand the requirements of the MIPS program, so typically, one person or a team is assigned to understand and manage the program successfully. This places a burden on the practice to devote financial resources to managing MIPS. Those who learn MIPS' requirements soon discover that their legacy EMR and practice management systems are not equipped to automate the many tasks required to successfully manage and report information to CMS during the annual reporting period (January to March after the 12-month reporting year).

If a practice isn't successful at reporting, the penalty for non-reporting or achieving a score of less than 75 out of a 100-point scale can be as much as -9% on CMS claims the following year. In other words, CMS can levy a fee of up to 9% of a practice's Medicare Part B professional service reimbursements in the next year. In 2017, the penalty score was three points. Hence, CMS only required clinicians to submit minimal data on a single quality measure, one Improvement Activity, or the base measures for the Advancing

Care Information performance category. CMS has increased the penalty score to 75 points this year to motivate participation, a 25-fold increase from 2017.

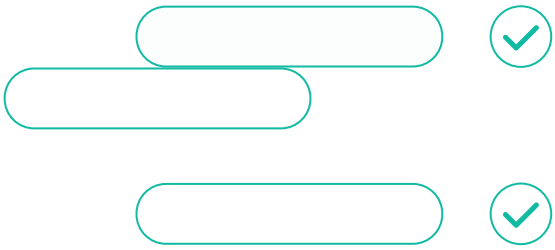
Additionally, during Covid, CMS allowed clinics and providers to request exceptions for reporting. These exceptions included the Extreme and Uncontrollable Circumstances Exception (EUC), which allowed clinicians not to report on one or multiple MIPS performance categories, and the Promoting Interoperability (PI) Performance Category Hardship Exception, which temporarily eliminated the PI reporting requirement. During the Covid pandemic, many practices grew accustomed to the lower bar for reporting, making the 75 score requirement a significant adjustment now that the Covid exceptions are expiring. Therefore, there is tremendous pressure to succeed with quality-reporting standards.

Amid this pressure, practice leaders reported in 2021 several challenges related to MIPs, including "MIPS' administrative burden, irrelevant measures (e.g., a general surgery practice does not generally administer flu vaccines), frequent programmatic changes, and small incentives."[4] Some practices even report that physicians care for fewer patients due to MIPS' administrative burden.

The Solution to MIPS' Administrative and Financial Burden on Independent Group Practices

Sharecare offers a MIPS consulting and reporting approach that takes advantage of its creation of a CMS-approved quality registry and a quality clinical data registry (QCDR). Both registries are intermediaries CMS offers for reporting due to the inability of legacy in-clinic technology to meet the demands of value-based reporting.

One way QCDRs can help improve the quality of care patients receive is by collecting clinical data from clinicians and reporting it to CMS on their behalf for purposes of MIPS. QCDR submission differs from qualified registry submission in that QCDRs can create measures and submit data on these measures, as well as standard MIPS quality measures. In addition, Sharecare's QCDR submits data for the Promoting Interoperability and Improvement Activities categories on behalf of the clinician(s).



5 Reasons Practices May Benefit from Using a QCDR

1. Specialty Focus Increases Relevant Quality Measures

Many QCDRs are specialty-based; for example, Sharecare's QCDR[5] includes exclusive measures that experts created for the orthopedic specialty, although their product works for all medical practices. Because QCDRs are typically designed for a specific patient population, they often include quality measures that are meaningful and relevant to that population and the procedures that serve that population.

2. Real-Time Feedback

QCDRs must deliver quarterly reports to clinicians, enabling them to identify and address relevant gaps in care that are significant to their specific patient population. While the minimum requirement is to provide reports every quarter, certain QCDRs also can generate real-time, daily reports, enabling practices to take immediate action for improvement if needed. Whether quarterly or real-time, these reports are a vast improvement over data dumps at the end of the year when it is too late to take action for that given year. Sharecare provides dashboards that allow clinicians to view results by practice, provider and patient.

3. Ability to Report All MIPS Categories

Most QCDRs can report across all MIPS categories, including quality, promoting interoperability, and improvement activities, making them a comprehensive solution for MIPS reporting. Clinicians and quality managers can consolidate various data types, including claims and information from their EHR and other systems, making a QCDR a convenient and efficient option for data aggregation.

4. MIPS Can Be Efficient and Cost-Effective

The specialty nature of many QCDRs allows the support and guidance they provide to be comprehensive and tailored specifically to the needs of the specialty, in contrast to the generic assistance offered by other vendors. With a QCDR, instead of spending time sorting through irrelevant measures, a practice's staff can focus only on specialty-specific measures.

5. QCDRs' Use Is Not Limited to MIPS

The QCDR measures represent an additional set of quality measures exclusively accessible for reporting through a QCDR. These measures may encompass specialty or disease-specific metrics that the MIPS inventory of quality measures does not include. This reduces the administrative burden of collecting and reporting data in multiple formats via multiple software programs. Currently, 46 QCDRs exist, with over 700 QCDR specialty measures. The complete list is available here.

Sharecare's Value-Based Care Solution

When deploying its MIPS product to a specific practice, Sharecare consults with that practice to determine its flows and processes to find the best, most relevant measures. Practices need at least 70% data completion on any given measure, so they must have some form of data collection to use a specific measure. A combination of good data and well-chosen measures scores the greatest number of points for practices. For example, outcome and high-priority measures that are benchmarked get 10 points.

Additionally, Sharecare integrates with a practice's EMR/practice management systems. It creates a data repository where Sharecare normalizes all the data, runs the algorithms defined in each measure, and offers visualization of the results on a centralized, integrated dashboard.[6]

Once a practice and Sharecare have selected the measures for that specific practice, integrated all software systems, and pulled data, the Sharecare dashboard goes live. After that point, Sharecare meets with clients at least every two months to proactively check on results, ensuring that there are no gaps and that the data is high quality. The combination of careful measure selection, integration with existing systems, real-time reporting, and ongoing adjustments with experienced MIPS consultants leads to a positive reporting result when a practice reports after the end of the year.

Finally, Sharecare helps practices with current and future reporting requirements that are no doubt coming. By integrating and aggregating a practice's data in a repository, normalizing the data, and calculating the results, Sharecare has enabled the practice to be value-based ready with CMS and any commercial payer or self-insured employer. This is vital because other non-CMS payers are introducing contracts based on quality measurements similar to CMS MIPS. Sharecare assists practices in managing more than 600 measures standardized within Healthcare Effectiveness Data and Information Set (HEDIS), ACOs, and other industry quality measurement policies and protocols.

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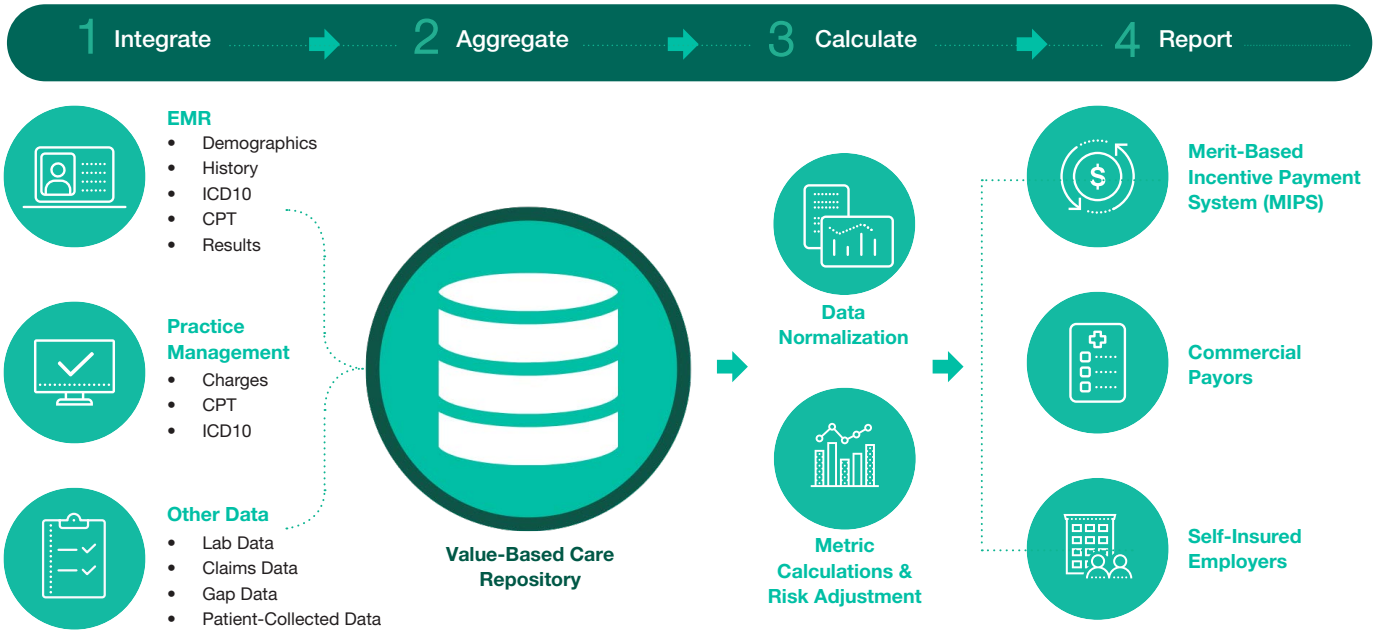

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Conclusion

With the fundamental shift from fee-for-service physician reimbursement to payment based on cost and the quality of outcome that patients derive from treatment, CMS initiated various programs under the Medicare Access and CHIP Reauthorization Act of 2015. Among these are the CMS MIPS quality reporting requirements. While MIPS has added significant administrative and financial burdens to Medicare Part B practices around the country, practices can mitigate these burdens with QCDRs such as Sharecare's, which is designed specifically for orthopedic practices but can benefit all specialties and general practices.

Practices do not have to carry the sole burden of MIPS reporting requirements, dedicate excessive staff hours and salary to meeting CMS's requirements, and risk losing 9% of their Medicare Part B reimbursements due to onerous reporting regimes. Sharecare is an expert with the clinical knowledge and technology to help in the immediate term and to set up practices to be value-based-ready as the trend spreads beyond CMS and into the rest of the healthcare industry. This is possible without additional IT investments beyond Sharecare's current solution.

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