MINGLE ANALYTICS SM

Transforming Healthcare through Data-Driven Solutions

PQRS SOLUTIONS SM

Pay for Performance Solutions

Pause to check

Any problems hearing or seeing the presentation?

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Logistics

- Ask Questions Anytime
- Type your questions into the GoToWebinar dialog box
- Email questions to us after the Webinar
- We will distribute a link to the slides and a recording of the Webinar

The PQRS Solutions Team

Nobody knows PQRS the way we do

Dr. Dan Mingle, MD, MS

- Family Physician and Educator
- Knows the business & practice of medicine
- Reporting PQRS since 2008
- Principle Architect for nine registries
- Feature in *Healthcare Informatics* magazine

Kash Basavappa

- Thirty years in healthcare and healthcare informatics
- Recipient of multiple awards as Chief Information Officer
- Directed development of commercial healthcare information technology products
- Working with Dr. Mingle since 2000

Assisted By

- PQRS Consultants providing
  - Client Support
  - Account Management
  - Project Management
- Data Analysts
- Development Staff

Gay De Hart

- Ten years in healthcare
- Practice Manager
- Business Writer – Grant Writer
- Working with Dr. Mingle since 2011

Scott Larsen

- 27 years in Information Technology
- 6 years in healthcare informatics
- Web Applications, Software as a Service
- Security Infrastructures
- Building environments that scale

Agenda

A. MIPS is Coming
B. 2016 PFS Final Rule Review:
    - Section H: Physician Compare Website
    - Section I: Physician Quality Reporting System
    - Section J: Clinical Quality Measures
    - Section M: Value-Based Payment Modifier
      Physician Feedback Program

PAY FOR PERFORMANCE SOLUTIONS

Details about PQRS, VBM, & MIPS

Part I, Sept. 29: Value-Based Modifier & Quality Tiering
Part II, Oct. 6: Unlocking the Quality and Resource Use Report
Part III, October 13: What We Know About MIPS

Register and access recordings:
http://pqrssolutions.com/webinars

Dr. Dan Mingle, CEO

It’s coming

2017

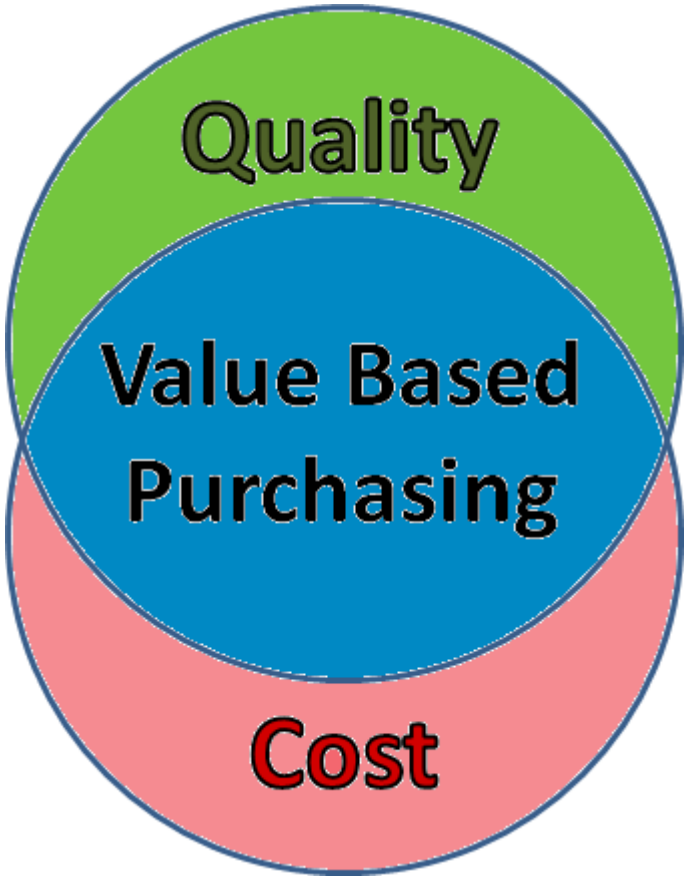
The Merit-Based Incentive Payment System

MIPS

A Healthcare System in Transition

Fee For Service

Centers for
Medicare and Medicaid
Services



Remix / Renaming

2016 (2018) is the Final Year in their current form:

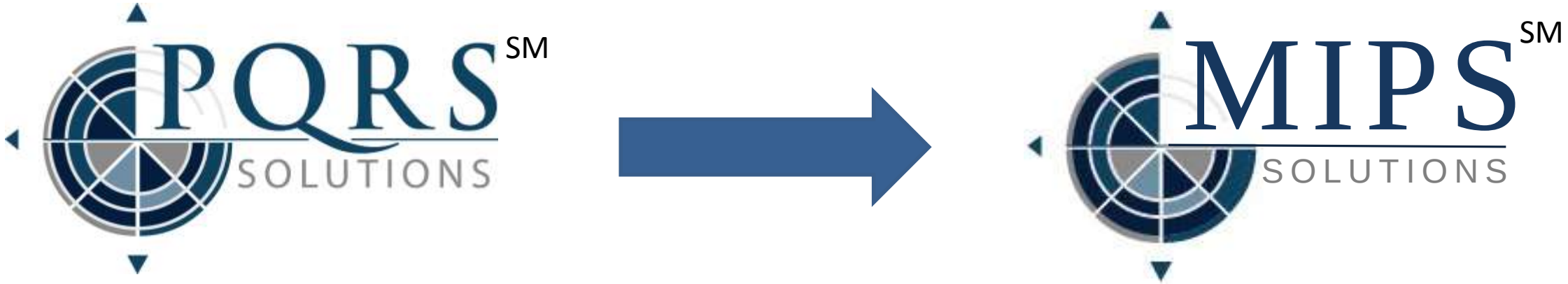
- Physician Quality Reporting System (PQRS)
- Value Based Modifier (VBM)
- Quality Tiering
- Meaningful Use

<u>Merit-Based Incentive Payment System (MIPS)</u>

- [(Quality Tiering + PQRS + VBM + EHR) + a – b] x N
  - Competition on a 100 point scale
    - 30 quality points
    - 30 resource use points
    - 25 meaningful use points
    - 15 practice improvement points
  - Increasing Adjustments
    - ±4% 2017 (2019)
    - ±9% 2020 (2022)

We'll Still Be Here For You

Nobody knows PQRS the way we do



Nobody knows MIPS the way we do

As Always

- Keep you informed of changes
- Your guide through confusing and contradictory rules
- Cost Effective Choices - for your unique circumstances
  - The right measures
  - The right mechanisms
  - The right data collection processes

Evolution of Mingle Analytics

- Automated Data Delivery Options
- More Reporting Mechanisms
  - Data Submission Vendor / EHR Direct
  - Web Interface Tool – ACO Reporting
  - Qualified Clinical Data Registry
  - Repurpose your Claims Submissions
- Support Meaningful Use
  - Specialized Registry
  - Clinical Quality Measures
  - Guidance / Strategies / Tools

HELP!
Document and Report
Best Possible Performance

- MIPS Mastery Collaborative
  - Network with your peers
  - Develop Meaningful Measures through our QCDR
  - Includes our
    - PQRS/MIPS Quality Reporting
    - Specialized Registry for MU
- MIPS Consulting Services
  - A-Z look at everything that feeds a performance score
    - People
    - Processes
    - Technology

Review of the 2016 Medicare PFS Final Rule

Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

CMS-1631-FC

Published in the Federal Register on 11/16/2015

Available online at http://federalregister.gov/a/2015-28005

Physician Compare

My Prediction:

Unchanged by MIPS

Required by the Affordable Care Act – 2010

(CMS is) committed to providing data on Physician Compare that are useful to beneficiaries in assisting them in making informed health care decisions, while being accurate, valid, reliable, and complete…

Medicare.gov | Physician Compare

The Official U.S. Government Site for Medicare

Viewing Profile 1 of 1

Dr. Seuss

Primary Specialty: Family Practice
Additional Specialty: Geriatric Medicine

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General Information | Locations

Quality Programs:

- ✔ Physician Quality Reporting System (PQRS)
- ✔ Electronic Health Records (EHR)

View information about Medicare quality reporting programs

Physician Compare Operating Principles

- All Measures and All Mechanisms are Now Eligible for Publication
- Measures Must Be
  - Statistically comparable
  - Statistically valid and reliable
  - Understood by consumers
  - Beyond Year 1 of use
- 20 Patient Minimum Sample
- Performance Benchmark Using Achievable Benchmark of Care (ABC™)
  - Stratify by mechanism and Group/Individual
- Display a 5-Star Rating System
- Practices Given 30-day Preview Period Before Publication

Physician Compare Progress

- Full Redesign in 2013
  - View information about approved Medicare professionals
  - Hospital affiliations that link to the hospital's profile on Hospital Compare
  - Group practice names, specialties, practice locations, Medicare assignment status, and affiliated professionals
- By Late 2016 – Publication Eligible
  - All Measures
  - All Mechanisms
  - All Practice Sizes
  - Including CAHPS for PQRS
  - Including QCDR
  - Including ACO
- EHR and Registry Data Eligible But Not Yet Reported
- 2018 PY Value Modifier Data (your 2016 service year data)
  - WILL NOT BE PUBLISHED ON PHYSICIAN COMPARE
  - WILL BE in the Downloadable Database

Physician Compare Resources

- Website URL:
  - http://www.medicare.gov/physiciancompare
- Data on Physician Compare comes from PECOS
  - https://pecos.cms.hhs.gov/pecos/login.do
- Specialty is as reported on your Medicare Enrollment Form
- Physician Compare support team
  - PhysicianCompare@Westat.com
- Physician Compare information and updates
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/

Pause for Questions about Physician Compare

PQRS

My Prediction:

Name Disappears but

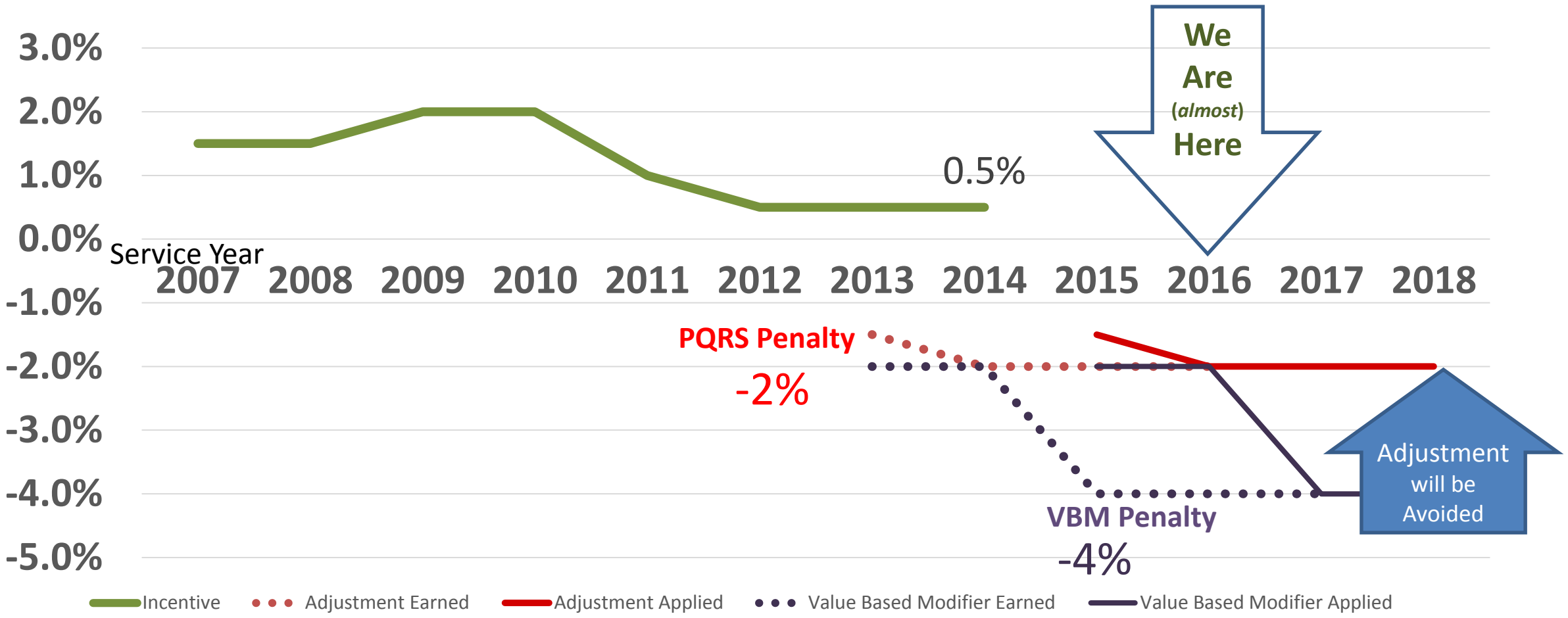
Program Continues to evolve within MIPS

Remember Medicare's Naming Conventions

The Program Year is Named for the Adjustment Year

- The 2018 Program Year
- Refers to Your 2016 Year of Patient Service
- That You Report in 2017
- The Adjustment is Applied to Payments for 2018 Patient Services
- Watch Out For Labels Such as 2016PY, 2016CY

No More Incentive *(except MOC)*
Adjustment stable at 2% (PQRS) and 2%-4% (VBM)

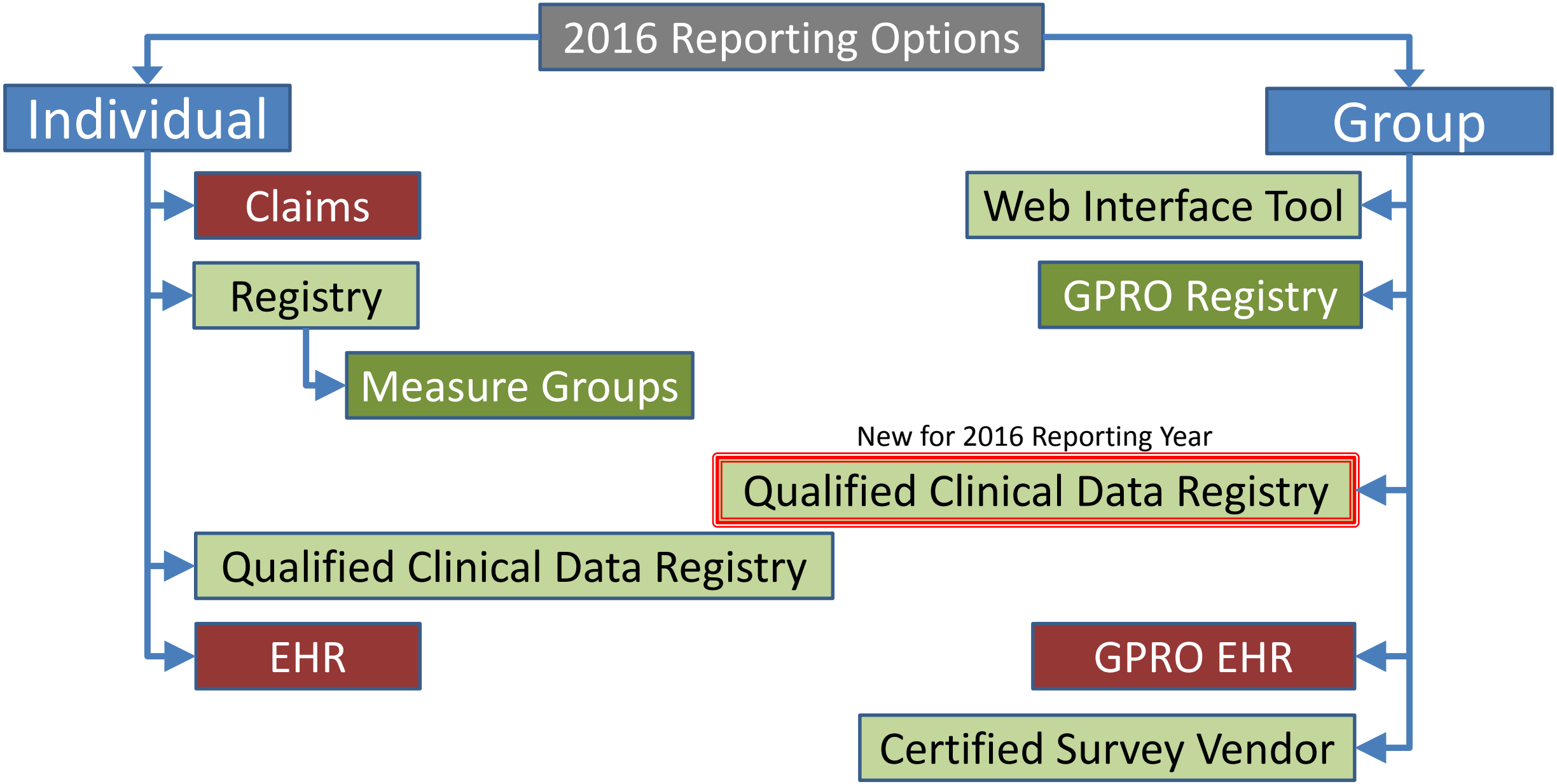


MOC

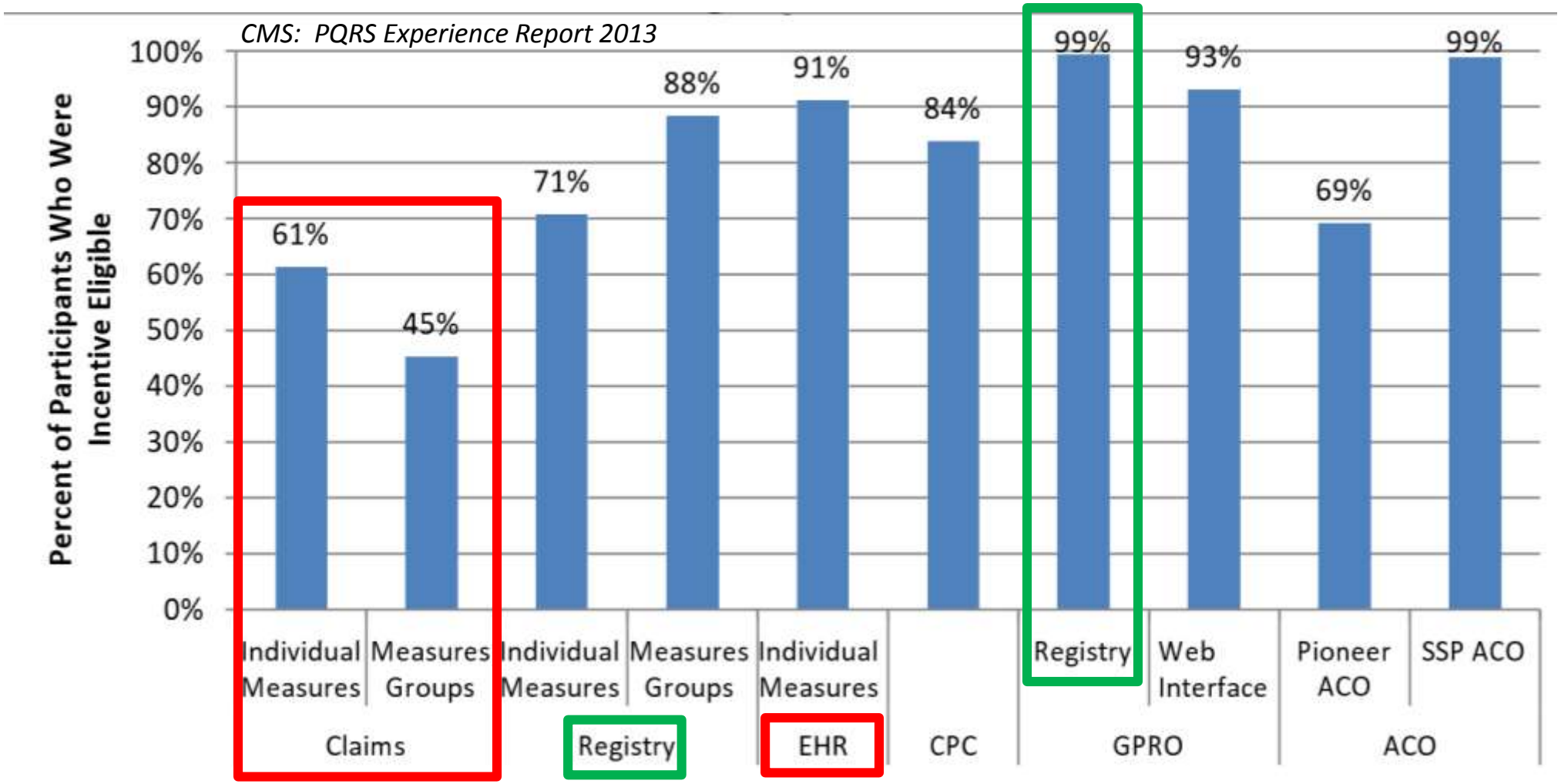
There is still a 0.5% Incentive
When PQRS is combined with a
Specialty Specific
Maintenance of Certification Program (MOC)

Who is Subject to PQRS?

- Essentially: Any Provider who Generates a Bill to Medicare Part B Covered by the Physician Fee Schedule
- Providers Employed by Critical Access Hospitals
  - NPI is now required in Type II billing
  - Can submit PQRS if NPI is on the bill
  - Will there be a penalty?
- Not Subject to PQRS:
  - FQHC
  - Independent Diagnostic Testing Facilities
  - Independent Laboratories



Incentive Eligibility Rate by the Physician Quality Reporting System Reporting Mechanism or Alternative Program (2013)



Reporting Basics Unchanged

- 9 Measures
- 3 Domains
- ≥ 50 % of Eligible Medicare Patients
- Any Measure with 0% Performance will not be Counted
- Submit 1 Cross-Cutting Measure
  - If there is at least 1 face-to-face visit
  - AND 15 Eligible instances for any Cross-Cutting Measure

Not Dead Yet

Claims Measures Continue to be De-Emphasized

In the 2015 Final Rule

Queued for elimination (date TBD)

Cited reason: high failure rate

CAHPS for PQRS

- Required for all Practices ≥ 100 Submitting GPRO
- Optional for all Group Practices ≥ 2
- Practice Bears the Expense
- Counts for 3 Measures, 1 Non-Specific Domain
- CAHPS is Based on 6 Months of Data, July 1 – December 31

3 New Measure Groups

- Cardiovascular Prevention Measures Group
- Diabetic Retinopathy Measures Group
- Multiple Chronic Conditions Measures Group

Measure Groups Requirements

- Only through Registry
- Submit 1 Measure Group
  - ≥ 20 Patients
  - ≥ 11 Medicare Patients
- If any measure has 0% performance the Measure Group will not be counted.

Web Interface Tool

- Only Applicable to GPRO Submissions for ≥ 25 Providers
- Must Have One Measure with Medicare Patient Data
- Groups ≥ 100 Providers Must also Submit CAHPS for PQRS
- Measures Increased From 17 → 18
  - #438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- For All Size Practices ≥ 25 Providers:
  - Report on first consecutive 248 eligible patients for each measure
  - Or all patients if < 248

Web Interface Patient Attribution

- Previously Aligned with SSP Attribution Methodology
- Now Aligned with VBM

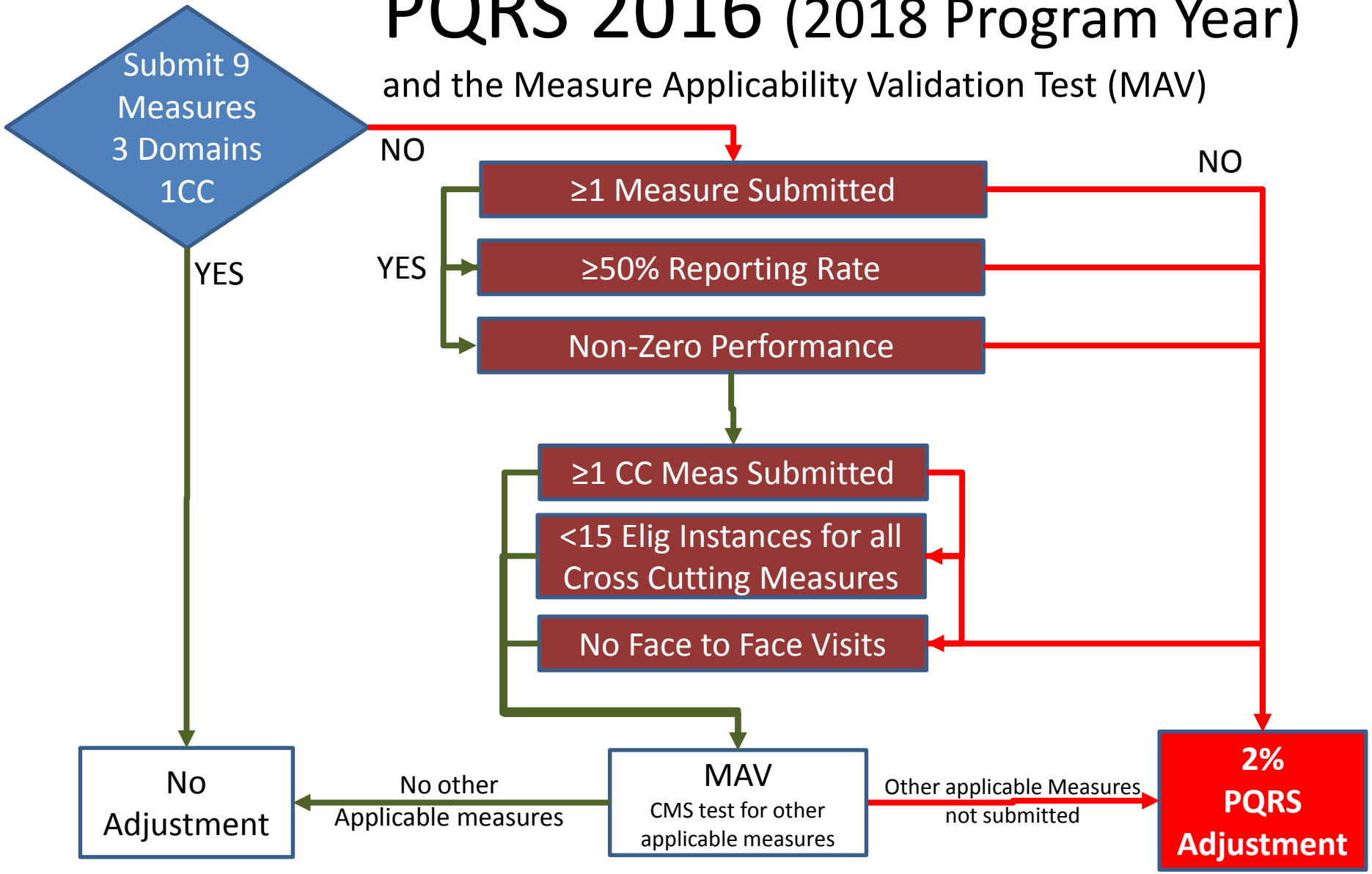
	Previous (SSP) Methodology	2016 (VBM) Methodology
Physician Assistant, Nurse Practitioner, Certified Nurse Specialist	Included in Step 2	Included in Step 1

Not Enough Measures?

- Claims and Registry Reporting
  - Measure Applicability Validation (MAV) is back
- EHR Reporting:
  - Submit what you've got
- Web Interface
  - Submit what you've got
- Qualified Clinical Data Registry
  - No excuses

PQRS 2016 (2018 Program Year)

and the Measure Applicability Validation Test (MAV)



GPRO Election Deadline

June 30 Annually

Elect GPRO and Commit to Method

Method is Now Flexible

Submission Deadlines

February 28 annually [EHR, DSV, QCDR(QRDA)]

March 21 annually (Web Interface)

March 31 annually [Reg, QCDR(xml)]

2016 Supported Method-Measures

	2014	2015	2016
Claims Measures	110	72	79
EHR (CQM) Measures	64	62	63
Registry Measures	201	175	198
Web Interface Measures	22	17	18
Measure Groups	24	22	25

4 New Cross-Cutting Measures

#	Topic	Mthd
1	Hemoglobin A1c control	C,R,E
46	Medication Reconciliation	C,R
47	Care Plan	C,R
110	Influenza	C,R,E
111	Pneumovax	C,R,E
112	Breast Cancer Screening	C,R,E
128	BMI and Plan	C,R,E
130	Current Medications	C,R,E
131	Pain Assessment and Plan	C,R
134	Screen for Depression and Plan	C,R,E
154	Falls: Risk Assessment	C,R
155	Falls: Plan of Care	C,R

#	Topic	Mthd
182	Functional Outcome Assessment and Plan	C,R
226	Tobacco Use and Plan	C,R,E
236	Controlling High Blood Pressure	C,R,E
240	Childhood Immunization Status	E
317	Screen for HTN and Plan	C,R,E
318	Screen for Fall Risk	E
321	CAHPS for PQRS Survey	S
374	Receipt of Specialist Report	E
400	Hepatitis C Screening	R
402	Tobacco Use and Plan in Adolescents	R,MG
431	Unhealthy Alcohol Use: Screening & Brief Counseling	R

12 Discontinued Measures

33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older
81	Adult Kidney Disease: Hemodialysis Adequacy: Solute
82	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening
193	Perioperative Temperature Management
194	Oncology: Cancer Stage Documented
285	Dementia: Screening for Depressive Symptoms
335	Maternity Care: Elective Delivery or Early Induction Without Medical Indication at ≥ 37 and < 39 Weeks
336	Maternity Care: Post-Partum Follow-Up and Care Coordination
349	Optimal Vascular Composite

Reasons to Discontinue Measures

1. Consistent and Universal Near-100% Performance
2. Consolidation/Deduplication
3. Failure to Identify a “Measure Steward”
4. Change in Standard of Care

1-10 of 37 New Measures

#	Title
403	Adult Kidney Disease: Referral to Hospice
404	Anesthesiology Smoking Abstinence
405	Appropriate Follow-up Imaging for Incidental Abdominal Lesions
406	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients
407	Appropriate Treatment of MSSA Bacteremia
408	Opioid Therapy Follow-up Evaluation
409	Clinical Outcome Post Endovascular Stroke Treatment
410	Psoriasis: Clinical Response to Oral Systemic or Biologic Medications
411	Depression Remission at Six Months
412	Documentation of Signed Opioid Treatment Agreement

11-20 of 37 New Measures

#	Title
413	Door to Puncture Time for Endovascular Stroke Treatment
414	Evaluation or Interview for Risk of Opioid Misuse
415	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older
416	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 through 17 Years
417	Rate of Open Repair of Abdominal Aortic Aneurysms (AAA) Where Patients Are Discharged Alive
418	Osteoporosis Management in Women Who Had a Fracture
419	Overuse Of Neuroimaging For Patients With Primary Headache And A Normal Neurological Examination
420	Varicose Vein Treatment with Saphenous Ablation: Outcome Survey
421	Appropriate Assessment of Retrievable Inferior Vena Cava Filters for Removal
422	Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury

21-30 of 37 New Measures

#	Title
423	Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy
424	Perioperative Temperature Management
425	Photodocumentation of Cecal Intubation
426	Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit (PACU)
427	Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU)
428	Pelvic Organ Prolapse: Preoperative Assessment of Occult Stress Urinary Incontinence
429	Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy
430	Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy
431	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
432	Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair

31- 37 of 37 New Measures

#	Title
433	Proportion of Patients Sustaining a Major Viscus Injury at the Time of any Pelvic Organ Prolapse Repair
434	Proportion of Patients Sustaining A Ureter Injury at the Time of any Pelvic Organ Prolapse Repair
435	Quality of Life Assessment for Patients with Primary Headache Disorders
436	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques
437	Rate of Surgical Conversion from Lower Extremity Endovascular Revascularizatio n Procedure
438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
439	Age Appropriate Screening Colonoscopy

Other Measure Changes

- Change Domains
- Change Reporting Mechanism Options
- Adjust Specific Eligibility or Performance Specifications
- Support of Exclusion or Ineligibility Statuses

Pause for Questions about PQRS

Clinical Quality Measures for Meaningful Use

My Prediction:

Continues under MIPS

Changes to Requirements

- CEHRT Must Submit Using Most Recent eCQM Specs
- CEHRT Need Not Recertify to Most Recent eCQM Specs
- EP May Still Attest or Submit Electronically
- 2015 Edition CQM Reporting Certification
  - QRDA Category I and III standards
  - Optional CMS “form and manner”

Comprehensive Primary Care Initiative

- Must Report CQM Electronically as a Group
- 13 Specified eMeasures
- 3 Domains
- EP in First Year of MU may Follow MU CQM Requirements or be Qualified by the Group Submission
- If CPC Practice Fails to Submit Group eCQMs, Individuals can Comply Individually with MU Requirements
- eSubmission Must be a 12-month (not 90-day) Reporting Period
- Use a Hardship Exemption in the First Year to Avoid Payment Reduction

Pause for Questions about Clinical Quality Measures for Meaningful Use

Value Based Modifier

My Prediction:

MIPS will most closely resemble VBM Quality Tiering.

Value Based Modifier Applies To:

2015 Service Year (2017 Program Year)

- Physicians – Doctors of:
  - Medicine
  - Osteopathy
  - Dental Surgery
  - Dental Medicine
  - Podiatric Medicine
  - Optometry
  - Chiropracty
- Solo and Group Practices that include at least 1 Physician

2016 Service Year (2018 Program Year)

- Physicians in Solo and Group Practices
- Non-Physicians in Solo and Group Practices (no Physicians in the Practice)
  - Nurse Practitioner
  - Physician Assistant
  - Certified Nurse Specialist
  - Certified Registered Nurse Anesthetist

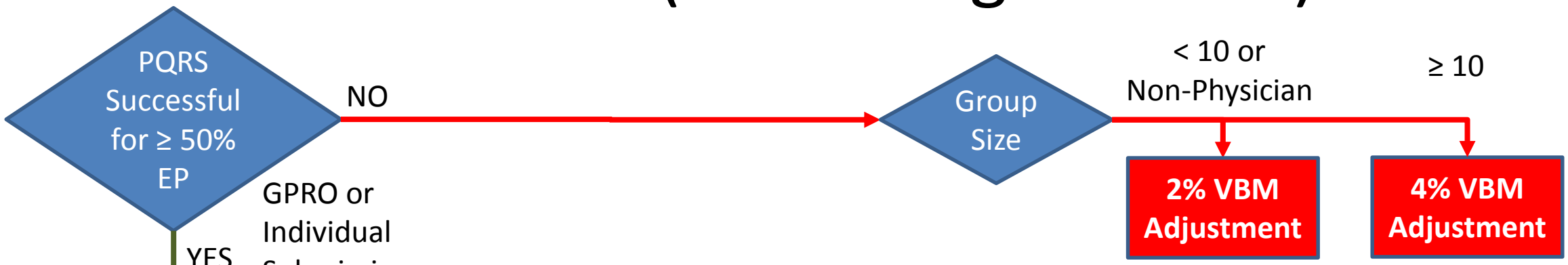
Mandatory Quality Tiering for All

Practice Type	Size	2015 Service Year		2016 Service Year	
		Max Negative	Max Positive	Max Negative	Max Positive
Physician Practice	≥ 10 EP	**-4%**	4%	**-4%**	4%
	1-9 EP	0	2%	**-2%**	2%
Non-Physician Practice	All Sizes	0	0	0	2%

Size of Practice

- Still Determined by the Lower Of:
  - Count of Providers in PECOS in early July
  - Count of Providers as of March 1 who billed Medicare Part B for the prior Service Year
- Also Determines if Your's is a Physician or Non-Physician Practice.
  - If either count yields 0 physicians, your's is a non-physician practice.

VBM 2016 (2018 Program Year)



80%

10%

10% Neg

Non-Physicians Group or Solo			
Low Quality	Avg Quality	High Quality	
0	+1x%	+2x%	Low Cost
0	0	+1x%	Avg Cost
0	0	0	High Cost

Physician Groups of 1 - 9			
Low Quality	Avg Quality	High Quality	
0	+1x%	+2x%	Low Cost
-1%	0	+1x%	Avg Cost
-2%	-1%	0	High Cost

Physician Groups of 10 or More			
Low Quality	Avg Quality	High Quality	
0	+2x%	+4x%	Low Cost
-2%	0	+2x%	Avg Cost
-4%	-2%	0	High Cost

Fiddling with Value Based Modifier

	2015 Service Year (2017 Program Year)	2016 Service Year (2018 Program Year)
Benchmarks		Separately Benchmark eCQMs
Minimum Cost Measure Sample Size	125 Attributed Patients	*No change*
Hospital Cost Inclusions		Include Maryland Hospitals
Applicability of VBM Adjustments	Group Adjustment applies to Physicians	Group Adjustment Applies to Physicians, NP, PA, CNS, CRNA
Benchmark Stratification	Cost Measures adjusted by Specialty and by Risk	*No change*
VBM waived if 50% of Individuals Submit	Whether or not Self-Selected for GPRO	*No change*
Permit Change in GPRO Method	Immediately	*No change*
All Cause Hospital Readmissions	Low Reliability Index therefore not Applicable to Groups 1-9 and Non-Physician Practices	*No change*
If any TIN provider is in an Innovation Model	Group is not Subject to VM	*No change*

Fiddling with Value Based Modifier

	2015 Service Year (2017 Program Year)	2016 Service Year (2018 Program Year)
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If any TIN provider is in an Innovation Model	Group is Not Subject to VM	

SSP ACO Policies in VBM

	2015 Service Year (2017 Program Year)	2016 Service Year (2018 Program Year)
If participating in > 1 ACO	Apply best ACO Quality Composite VBM Score	*No change*
If any TIN provider is in an Innovation Model	Group is Subject to VM	*No change*
ACO Does Not Successfully Report	Not Subject to Negative VBM Adjustment	Subject to Negative VBM Adjustment
If High Quality and ≥ 75th Percentile for beneficiary Risk Score	Add 1x% Positive Adjustment	*No change*
CAHPS for PQRS Survey		Included in Quality Composite Score

SSP ACO Policies in VBM

	2015 Service Year (2017 Program Year)	2016 Service Year (2018 Program Year)
If participating in > 1 ACO	Apply best ACO Quality Composite VBM Score	
If any TIN provider is in an Innovation Model	Group is Subject to VM	
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If High Quality and ≥ 75th Percentile for beneficiary Risk Score	Add 1x% Positive Adjustment	
CAHPS for PQRS Survey		Included in Quality Composite Score

Pause for Questions about Value Based Modifier

Physician Feedback Program and Informal Review

My Prediction:

Continue to evolve under MIPS.

Likely to be consolidated.

Mid-Year QRUR Report

- First Distributed in Spring 2015
- Provided by TIN to Physicians in Group and Solo Practice
- Cost and Administrative Claims Calculated Measures
- Most Recent July 1 through June 30 Reporting Period
- Expand in Spring 2016 to Non-Physicians in Group and Solo Practice

Supplemental QRUR Report

- First Distributed in Summer 2014
  - Provided by TIN to Groups ≥ 100
  - Episodes of Care that occurred in 2012
    - 6 Major Episode Measures
    - 20 Episode Subtypes
- Distributed in Fall 2015
  - Provide by TIN to Group and Solo Providers
  - Episodes of Care that occurred in 2014
    - 26 Major Episode Measures
    - 38 Episode Subtypes

Quality and Resource Use Report (QRUR)

- Annual Report for TIN Practices
- This is THE Report that Documents Your VBM Adjustment
- Available in Your CMS Enterprise Portal (PV-PQRS) Aug-Sept
- Contains:
  - Cost Performance
  - Quality Performance
  - Specialty and Risk Adjusted
  - VBM Adjustment
    - Calculations
    - Details

PQRS Feedback Report

- Specific PQRS Performance Feedback
- All PQRS Methods Utilized
- Qualification Status
- Allowable Charges and Calculated Incentive
- Anticipated Adjustment

Informal Review for PQRS

- Must be Requested Within 60 Days Following Publication of the Feedback Report
- Data can be RESUBMITTED (if infrastructure exists):
  - Not submitted for the first time.
  - Must be by a third-party.
  - Not available for Claims, EHR Direct, or Web Interface.
- No Administrative or Judicial Review of Determinations

Informal Review for VBM

- Requests due 60 days after Publication of QRUR
- Intended as a Means to correct Certain Errors Made by CMS or a Third-Party Vendor (for example, PQRS-qualified Registry)
- Possible Actions:
  - Classify as average
  - Resubmit/recalculate quality metrics
- No Administrative or Judicial Review of Determinations

Questions and Discussion

Dan Mingle, MD MS, Founder and CEO
Daniel.Mingle@MingleAnalytics.com

PQRS Solutions™ by Mingle Analytics
(866)359-4458
www.MingleAnalytics.com

VBM 2016 (2018 Program Year)

Non-Physicians Group or Solo			
Low Quality	Avg Quality	High Quality	
0	+1x%	+2x%	Low Cost
0	0	+1x%	Avg Cost
0	0	0	High Cost

Physician Groups of 1 - 9			
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-1%	0	+1x%	Avg Cost
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Physician Groups of 10 or More			
Low Quality	Avg Quality	High Quality	
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-2%	0	+2x%	Avg Cost
-4%	-2%	0	High Cost