Starting at
Noon EDT
11/9/2016

2017 Final Rule for MIPS/MACRA Medicare's New Quality Payment Program

Dr. Dan Mingle

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http://mingleanalytics.com/webinars

2017 Final Rule for MIPS/MACRA Medicare's New Quality Payment Program

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Agenda

- Dispel Rumors
  - Of the demise of PQRS and Meaningful Use
  - Of the Delay of MIPS/MACRA
- Overview of Medicare’s New Quality Payment Program (QPP)
- A favorable Comparison to the Old Programs
- 2017: A Year of Transition, Iterative Learning, and Development
- How does it all fit together
- Is there a pathway to success?

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Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

- Final Rule Available for View 10/14/2016
- Published on the Federal Register 11/4/2016
- Comment Period open through 12/19/2016
- Effective 1/1/2017

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Medicare Access and CHIP Reauthorization (MACRA)
Signed into Law April 2015

It Was Rumored:

Physician Quality Reporting System (PQRS) is OVER!

Meaningful Use (MU) is OVER!

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Don't Believe It!

PQRS and Meaningful Use
2016 Final Submissions are Due March 2017
Penalties and Incentives Pay out through 2018

Physician Quality Reporting System (PQRS) → MIPS Quality Performance Category

Medicare EHR Incentive Program (aka: Meaningful Use) → **MIPS Advancing Care Information Performance Category**

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Medicaid Meaningful Use is Unchanged
Still in effect

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Medicare Acting Administrator, Andy Slavitt Announced on September 8, 2016

“Pick Your Pace”

It Was Rumored:

MIPS is Postponed!

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Not True!

- MACRA/MIPS will start as scheduled January 1, 2017 as
- A Year of Transition, Iterative Learning, and Development
- Builds to the same crescendo
- With a kinder/gentler Start
- (Almost) No Excuse to earn a negative adjustment in Year 1

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Timeline

Event	Begin Date	End Date
PQRS and MU 2016 Performance Year (the Last Year)	January 1 to	December 31, 2016
PQRS and MU 2016 Payment Year (2014 Performance)	January 1 to	December 31, 2016
PQRS and MU 2017 Submission Window 2016 Data	January 2 to	March 31, 2017
MIPS 2017 Performance Period (the First Year)	January 1 to	December 31, 2017
PQRS and MU 2017 Payment Year (2015 Performance)	January 1 to	December 31, 2017
MIPS 2018 Submission Window 2017 Data	January 2 to	March 31, 2018
MIPS 2018 Performance Period	January 1 to	December 31, 2018
PQRS and MU 2018 Payment Year (2016 Performance)	January 1 to	December 31, 2018
MIPS 2019 Submission Window 2018 Data	January 2 to	March 31, 2018
MIPS 2019 Performance Period	January 1 to	December 31, 2019
MIPS 2019 Payment Year (2017 Performance)	January 1 to	December 31, 2019

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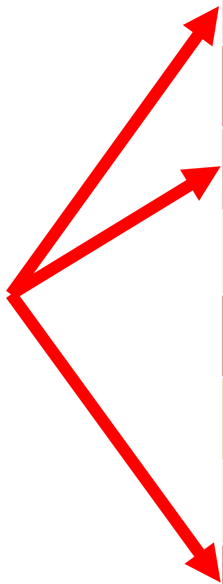
Performance – Reporting – Payment Cycle for The Final Year of PQRS



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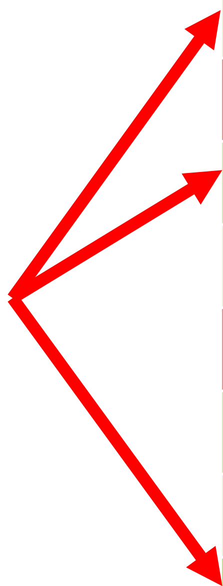
Performance – Reporting – Payment Cycle for The First Year of MIPS



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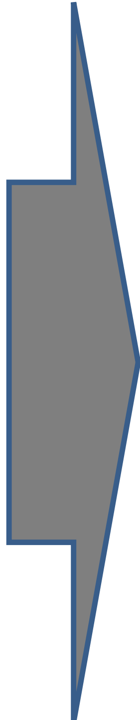
Physician Quality Reporting System (PQRS)

Value Based Modifier (VBM or VM)

Quality Tiering

Medicare EHR Incentive Program (aka: meaningful use)



Quality Payment Program(QPP)

First Pathway

Alternative Payment Models (APM)

- APM Type
- APM Entity
- Advanced APM
- Qualifying Participants (QP)
- Partial QP
- Split TIN

Second Pathway

Merit-Based Incentive Payment System (MIPS)

- Eligible Clinicians
- Virtual Groups

2016	Last Reporting Year
March 31, 2017	Last Submission Due
2018	Last Payment Adjustments Applied

2017	First Reporting Year
March 31, 2018	First Submission Due
2019	First Payment Adjustments Applied

Effective Date January 1, 2017

Comments will be considered if received by December 19, 2016 at

https://www.regulations.gov

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MIPS will consolidate components of three existing programs:

- Physician Quality Reporting System (PQRS)
- Physician Value-based Payment Modifier (VM)
- Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs)

Will continue the focus on quality, cost, and use of certified EHR technology (CEHRT)

In a cohesive program that avoids redundancies

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CMS supports the nation's progress toward achieving

- a patient-centered health care system
- that delivers better care
- smarter spending
- healthier people
- healthier communities

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6 Strategic Objectives

1. Improve beneficiary outcomes and engage patients through patient-centered Advanced APM and MIPS policies
2. Enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools
3. Increase the availability and adoption of robust Advanced APMs
4. Promote program understanding and maximize participation through customized communication, education, outreach and support that meet the needs of the diversity of physician practices and patients
   a. Especially the unique needs of small practices
5. Improve data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders
6. Ensure operational excellence in program implementation and ongoing development.

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The bedrock of the Quality Payment Program is high-quality, patient-centered care followed by useful feedback, in a continuous cycle of improvement.

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2017

"Transition Year and Iterative Learning and Development Period"

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Characteristics of the Transition Year

- Could last 2 years
- Pick your Pace
- Cost Weighted @ 0 points
- Quality Weighted @ 60 points
- Thresholds
  - Performance @ 3
  - Exceptional Performance Bonus @ 70
    ($500m pool)

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Pick Your Pace

Option	Definition	Outcome
All In	Report to MIPS for a full 90-day period or the full year	Eligible for • Full Positive Adjustment • Exceptional Performance Bonus
Some Data	Report for a minimum 90-day period • more than one quality measure, or • more than one improvement activity, or • more than the required measures in ACI	Avoid Negative Adjustment Eligible for Partial Positive Adjustment
One Measure	Report • One Quality Measure, or • One CPIA, or • Just the Required ACI Measures	Avoid Negative Adjustment
APM	Participate in an Advanced APM	Eligible for 5% Positive Adjustment if Qualified
Do Nothing		4% Negative Adjustment

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All In Requirements

- Quality Measures Options
  - 6 Measures

    or
  - One Specialty Specific Measure Set
- Advancing Care Information (ACI)
  - 5 Required Measures in Base Score
- Clinical Practice Improvement Activities
  - 4 Activities for Maximum Possible Score 40
- NO Cost or Resource Use in Year 1!

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MIPS Eligible Clinicians (EC)

- for the first 2 years
  - Physician (doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, optometry, and chiropracty)
  - Physician Assistant (PA)
  - Nurse Practitioner (NP)
  - Clinical Nurse Specialist (CNS)
  - Certified Registered Nurse Anesthetist (CRNA)

- Secretary has discretion to specify additional ECs starting in year 3 which may include
  - Certified Nurse Midwife
  - Clinical Social Worker
  - Clinical Psychologist
  - Registered Dietician or Nutrition Professional
  - Physical or Occupational Therapist
  - Speech-Language Pathologist
  - Audiologist

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In/Out

- Independent Testing Facilities – Out
  - Professional services IN when billed by an Eligible Clinician (NPI)
- CAH with Method II Billing – In
- CAH with Method I Billing – Providers are In
- FQHC and RHC in for Part B Billing

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MIPS Excluded Clinicians

- Newly Medicare-enrolled eligible clinicians
- Qualifying APM Participants (QPs)
- Certain Partial Qualifying APM Participants (Partial QPs),
- Clinicians that fall under the low-volume threshold
  - Individual or Group with

    ≤ $30,000 Allowable Charges

    OR

    ≤ 100 unique Medicare Beneficiaries

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Low Volume Threshold

- Allowable Charges ≤ $30k

OR

- Unique Patients ≤ 100
- 2-year Low-Volume Threshold Determination Period (LV if either year is LV)

For 2017 Performance Period

1. 9/1/2015 – 8/31/2016 (with 60d runout)
2. 9/1/2016 – 8/31/2017 (with 60d runout)

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Non-Patient Facing MIPS Eligible Clinicians

- Defined:
  - Individuals with ≤ 100 Patient Facing Encounters
  - Groups where > 75% of individual clinicians have ≤ 100 Patient Facing Encounters
- 25% of MIPS Eligible Clinicians are NPF
- Includes most: Pathologists, Anesthesiologists, Nuclear Medicine, Diagnostic Radiology
- Telehealth services are considered Patient Facing
- 2-year Non-Patient Facing Determination Period (NPF if either year is NPF)

For 2017 Performance Period

1. 9/1/2015 – 8/31/2016 (with 60d runout)
2. 9/1/2016 – 8/31/2017 (with 60d runout)

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Composite Performance Score

Performance Year	Report by March 31	Payment Year	Quality	Cost	Clinical Practice Improvement Activity	Advancing Care Information
2017	2018	2019	60	0	15	25
2018	2019	2020	50	10	15	25
2019	2020	2021	30	30	15	25
…	…	…	30	30	15	25

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Quality
Performance Category

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Quality Performance Category

- 6 Reported Measures Including
  - 1 Outcome, Intermediate Outcome, or High Priority Measure
  - 50% Reporting Rate
  - All Payers data set
- 1 Administrative Claims Measure
  - All cause Readmissions
  - Only if Group size > 15 and

  ≥ 200 attributed Hospitalizations

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Data Completeness Threshold

	Payers	Reporting Rate 2017	Reporting Rate 2018	Period 2017
Claims	Medicare Part B	50%	60%	90 days
Web Interface	Medicare Part B	248 patients	248 patients	90 days
Qualified Registry	All	50%	60%	90 days
QCDR	All	50%	60%	90 days
EHR/DSV	All	50%	60%	90 days

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Quality Measure Bonus Points

- 2 Points for Extra Outcome or Patient Experience Measures
- 1 Point for any other high priority measure
- Bonus Points Capped at 10% of Denominator

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Electronic Submission Bonus Points

- End to End Electronic Reporting Bonus point for each measure
- Bonus Points Capped at 10% of Denominator
- Clinical Data must be documented in CEHRT
- Processing must not include abstraction or pre-aggregation
- All Mechanisms Eligible except Claims
  - Electronic Health Record Direct
  - Data Submission Vendor
  - Qualified Registry
  - Qualified Clinical Data Registry
  - Web Interface

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A submission would be awarded bonus for end-to-end reporting only if the submission included uploading an electronic file without modification.

This is to preserve the electronic flow of data end-to-end and provide a verifiable method to ensure that manual abstraction, manual calculation, or subsequent manual correction or manipulation of the measures using abstraction did not occur.

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Too Few Measures?

- Missing measures are scored 0 and averaged in with those submitted
- Watch for a Measure Applicability Validation Test in 2018
- Need not go beyond the measures in your Specialty or Subspecialty Measure Set
- Not scored (averaged in) if denominator < 20

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Topped Out Measures

- Definition
  - Process measures | median performance rate ≥ 95%
  - Non-process measures | Truncated Coefficient of Variation < 0.1 and 75th and 90th percentiles within 2 standard errors
- Scored at the Median Score for the clustered Performance
- Scoring will not be adjusted until a year after it is identified as topped out
- 2018 will be the first year that any measure can be scored using this methodology

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Transition Year Measure Policies

Measure Type	Description	Scoring Rules
Class 1 – Measure can be scored based on performance	1) The measure has a benchmark; 2) Has at least 20 cases; and 3) Meets the data completeness standard (generally 50 percent.)	Receive 3 to 10 points based on performance compared to the benchmark.
Class 2 – Measure cannot be scored based on performance and is instead assigned a 3-point score	1) Do not have a benchmark, 2) Do not have at least 20 cases, or 3) Measure does not meet data completeness criteria	Receive 3 points Note: This Class 2 measure policy does not apply to CMS Web Interface measures and administrative claims-based measures.

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Resource Use
(Cost)
Performance Category

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Resource Use (Cost) Measures

- Total per capita costs for all attributed beneficiaries
  - Annual costs per beneficiary from all sources
  - Attributed to one Primary Care Provider (group)
- Medicare Spending per Beneficiary (MSPB)
  - Charges attributed to inpatient stays
  - Attributed to provider (group) with plurality of charges
- Episodes of Care
  - 10 anticipated in 2018
  - 40 being tracked

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Transition Year Cost Policies

- Weighted at 0 for 2017 Performance (2019 Payment) Year
- Weighted at 10 for 2018 Performance (2020) Payment Year

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Clinical Practice Improvement Activities (CPIA) Performance Category

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Clinical Practice Improvement Activities

- PCHM = Maximum Possible Points (40)
- APM Participation = 50% of Maximum Possible Points (20)
- High Weighted Activities = 20 Points
- Medium Weighted Activities = 10 Points
- Maximum = 40 Points

Participation Thresholds

- 90 days required
- No Practice or Provider Participation thresholds

Special Populations: Points Doubled for

- Practice with ≤ 15 Providers
- Rural Practice
- HPSA Practices
- Non-patient facing MIPS Eligible Clinicians

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Advancing Care Information (ACI) Performance Category

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ACI Scoring (2015 Edition)

Objective	Measure	Base Score	Perf Score	Report
Protect Patient Health Information	Security Risk Analysis	Required	NA	Yes/No
Electronic Prescribing	e-Prescribing	Required	NA	Num/Den
Patient Electronic Access	Provide Patient Access	Required	Up to 10%	Num/Den
	Patient-Specific Education		Up to 10%	Num/Den
Coordination of Care Through Patient Engagement	View, Download, or Transmit (VDT)		Up to 10%	Num/Den
	Secure Messaging		Up to 10%	Num/Den
	Patient-Generated Health Data		Up to 10%	Num/Den
Health Information Exchange	Send a Summary of Care	Required	Up to 10%	Num/Den
	Request/Accept Summary of Care	Required	Up to 10%	Num/Den
	Clinical Information Reconciliation		Up to 10%	Num/Den
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting		0 or 10%	Yes/No

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ACI Scoring (2014 Edition)

Objective	Measure	Base Score	Perf Score	Report	
Protect Patient Health Information	Security Risk Analysis	Required	NA	Yes/No	
Electronic Prescribing	e-Prescribing	Required	NA	Num/Den	
Patient Electronic Access	Provide Patient Access	Required	Up to 20%	Num/Den	
	View, Download, or Transmit (VDT)		Up to 10%	Num/Den	
Patient-Specific Education	Patient-Specific Education		Up to 10%		
Secure Messaging	Secure Messaging		Up to 10%	Num/Den	
Health Information Exchange	Health Information Exchange	Required	Up to 20%	Num/Den	
Medication Reconciliation	Medication Reconciliation		Up to 10%	Num/Den	
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting		0 or 10%	Yes/No	

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ACI Bonus Points

Objective	Measure	Bonus	Report
Public Health and Clinical Data Registry Reporting	Syndromic Surveillance Reporting	5%	Yes/No
	Electronic Case Reporting		Yes/No
	Public Health Registry Reporting		Yes/No
	Clinical Data Registry Reporting		Yes/No
Report improvement activities using CEHRT		10%	Yes/No

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ACI Exclusions

- Excluded if ≥ 75% of charges in POS 21, 22 or 23
  - Hospital Based Determination Period (9/1 thru 8/31 2 years prior)
  - ACI reweighted to 0
  - ACI points awarded if reported
- Hardship Exclusions
  - Insufficient Internet
  - Extreme and Uncontrollable Circumstances
  - Lack of Control over Availability
  - Lack of Face to Face patient Interaction
- Apply for Reweighting (Hardship) by 3/31 submission deadline
- New Clinicians to CEHRT: NP, PA, CRNA, CNS
  - ACI reweighted to 0
  - ACI points awarded if reported

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Alternative Payment Models (APM)

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Advanced APM Qualified Participants (QP)

Anyone who bills Medicare Part B can participate and earn 5% Incentive

- Physician (doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, optometry, and chiropracty)
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Registered Dietician or Nutrition Professional
- Physical or Occupational Therapist
- Speech-Language Pathologist
- Audiologist

- Critical Access Hospitals (CAH)
- Federally Qualified Health Centers (FQHC)
- Rural Health Centers (RHC)

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Alternative Payment Models

APM

- Medicare Shared Savings Program, Track 1
- Earn 50% of CPIA score
- Upside gains
- Nominal if any downside risk
- Special Reporting Considerations

Advanced APM

- Upside gains
- More than Nominal downside risk
- Eligible for 5% Incentive (5 years)
- Then favorable PFS conversion rate
- Earn 50% of CPIA score
- Special Reporting Considerations

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APM

- Rapid Expansion of Options
- More Aggressive Goals/expectations
  - 2017: 70,000 – 120,000
  - 2018: 125,000 to 250,000

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How does it all fit together?

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MIPS Year 1 Original Proposal

From the CMS Proposed Rule

Performance Threshold = 60

Adjustment Factor + Additional Adjustment Factor

Adjustment Factor

Adjustment Factors

10%
8%
6%
4%
2%
0%
-2%
-4%
-6%

0 10 20 30 40 50 60 70 80 90 100

Composite Performance Score

Conceptual Model of MIPS Year 1

From the CMS Proposed Rule

2017
Reporting
Year

2019
Payment or
Program
Year

Pmt Year	Adj Factor
2019	± 4%
2020	± 5%
2021	± 7%
2022	± 9%

Conceptual Model of MIPS Year 1

From the CMS Proposed Rule

2017 Reporting Year

Pmt Year	Adj Factor
2019	± 4%
2020	± 5%
2021	± 7%
2022	± 9%

2019 Payment or Program Year

	Quality	Cost	ACI	CPIA
2020	50	10	25	15
2021	30	30	25	15
2022	30	30	25	15

MIPS Year 1 Original Proposal

From the CMS Proposed Rule

2017
Reporting
Year

2019
Payment
or
Program
Year

Performance
Threshold = 60

Adjustment Factor
+ Additional
Adjustment Factor

Collect $833 million from the Losers to Distribute amongst the Winners

Adjustment
Factor

Adjustment Factors

10%
8%
6%
4%
2%
0%
-2%
-4%
-6%

0 10 20 30 40 50 60 70 80 90 100

Composite Performance Score

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2017 (2019) Transition Year Plan

Performance Threshold = 3

Adjustment Factor + Additional Adjustment Factor

Adjustment Factor

Adjustment Factors

4%
3%
2%
1%
0%
-1%
-2%
-3%
-4%
-5%

0 10 20 30 40 50 60 70 80 90 100

Final Score

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2017 (2019) Transition Year Plan

Collect $199 million from the Losers to Distribute amongst the Winners

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Final Score Points	MIPS Adjustment
0-0.75	Negative 4 percent (Note: We anticipate that this range will comprise mostly of MIPS eligible clinicians with a final score of 0.)
0.76-2.9	Negative MIPS payment adjustment greater than negative 4 percent and less than 0 percent on a linear sliding scale. (Note: We do not anticipate many MIPS eligible clinicians to fall into this range.)
3.0	0 percent adjustment
3.1-69.9	Positive MIPS payment adjustment ranging from greater than 0 percent to 4 percent × a scaling factor to preserve budget neutrality, on a linear sliding scale
70.0-100	Positive MIPS payment adjustment AND additional MIPS payment adjustment for exceptional performance. (Additional MIPS payment adjustment starting at 0.5 percent and increasing on a linear sliding scale to 10 percent multiplied by a scaling factor.)

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Other MIPS Notes

- Physician Compare and Hospital Compare will continue to be Populated and enhanced
- Physician Feedback Reports will continue to be offered and enhanced
- Informal Review to be continued

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Is there a pathway to Success?

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New Paradigm

- You are in competition for Top Dollar
- Performance Matters
  - Invest in Measures that Matter
  - Have extra measures in the hopper
  - Submit extra measures
  - Understand and improve the Data Value Stream
    - Care → Documentation → Extraction → Translation → Submission
- Contain Costs
  - Data is not readily available
  - Understand and improve the cost Value Stream
    - Patient Centeredness → Accessibility → Planned Care → Avoid Excess
- Engage in a continuous feedback and improvement cycle

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Performance Optimization and the Mingle MUSE Collaborative

Optimal Element	Determinant of Quality
Establish a Protocol	Evidence Based and Cost Effective Best Practice Deviations from Protocol are welcome → improve the protocol
Move the Care and Documentation Forward	Put it in the patients' hands where possible Otherwise as close to first contact as possible, and in lowest capable credentials and pay level
"Measure Twice, Cut Once"	Collect and record once in a standard location. Continually check for accuracy. Eliminate unnecessary redundancy.
Build simple, efficient, standard templates	3 simple rules: Simplify, Integrate, Standardize
Train	Train everyone to the new care delivery and documentation protocols
Extract and measure	Build effective queries. Track performance over time. Apply statistical process controls
Monitor	Monitor performance and selectively remediate (retrain)
Continuous Improvement	Protocols, templates, training, monitoring, extraction, reporting

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Mingle Infrastructure for Medicare's
Quality Payment Program

Continued Excellence

- Highly Available
- Highly Affordable
- Highly Effective

A Comprehensive set of QPP Products and Services

- All Mechanisms
  - Qualified Registry
  - Qualified Clinical Data Registry
  - EHR based Reporting (EHR and DSV)
  - Web Interface Electronic Submissions
- All Measures
- All Performance Categories
- Advanced Analytics
  - Benchmarking and comparisons
  - Trending
  - Predictive Analytics
- Continuous Automated Data Flow and Access to Metrics
  - Roll up
  - Drill down
- Advanced and continuous help
  - Mingle's MUSE Collaborative Learning Collaborative
  - Boots-on-the-Ground Consultancy

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Thank You

Ask your questions now or

Send by email to daniel.mingle@mingleanalytics.com

Register for Webinars or Access Recordings @ http://mingleanalytics.com/webinars

There is still time to engage us to help with your 2016 PQRS and VM Submissions

Join our MUSE Collaborative for a Data-Driven learning and improvement process
To help you rise to earn your highest possible MIPS Adjustment

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