MINGLE ANALYTICS

Starting at
Noon EST
Wed 12/6/2017

2018 Final Rule from CMS for the Quality Payment Program

Dr. Dan Mingle

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Agenda

- First Quality Payment Program rule under the new Republican Administration
- Important Reminders
  - Comment on the Final Rule
  - QPP 2017
- Overview of QPP 2018
  - The new “Basics” of the Merit Based Incentive Payment System (MIPS) 2018
- Significant Hardship Exceptions
- The “Interim Final Rule” and Extreme and Uncontrollable Circumstances
- Look for our Final Rules Webinar regarding Alternative Payment Models at a later date

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Timeline

- Proposed Rule Published 6/30/2017
- Unofficial Version Final Rule released 11/2/2017
- Official Version to be published 11/16/2017
- Effective January 1, 2018
- Comments accepted through 5PM EST January 1, 2018
  - Submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the ‘‘Submit a comment’’ instructions.
  - Refer to CMS–5522–FC when commenting on issues in the final rule
  - Refer to CMS-5522-IFC when commenting on issues in the interim final rule

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Comments on the Final Rule accepted through 5PM EST January 1, 2018

https://www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-programs-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme

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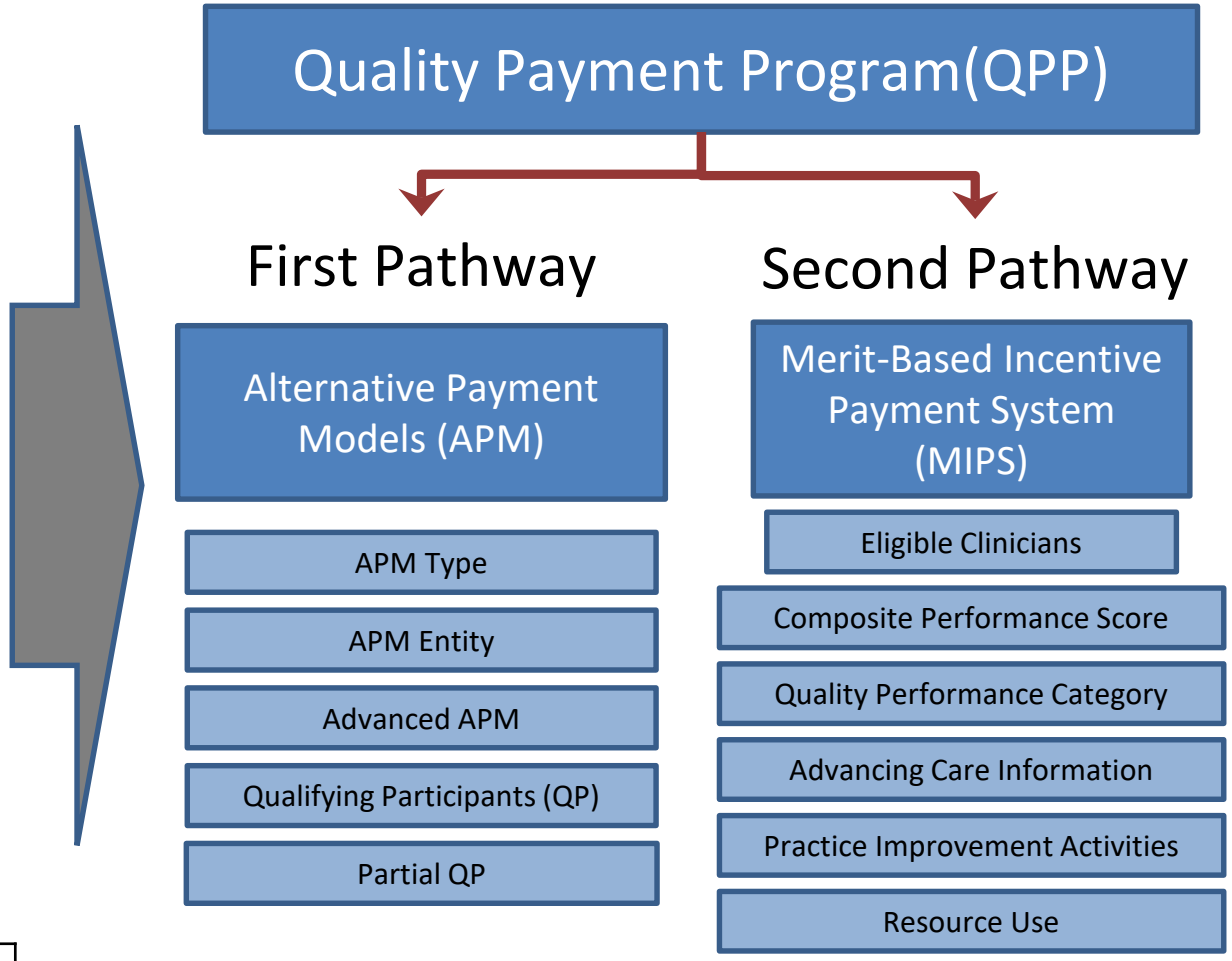
Physician Quality Reporting System (PQRS)

Value Based Modifier (VBM or VM)

Quality Tiering

Medicare EHR Incentive Program (aka: meaningful use)



March 31, 2017	Last PQRS Submissions Made
Dec 1, 2017	Last day to Request Informal Review
2018	Last PQRS and VBM Payment Adjustments Applied

Jan 1, 2018	Start of 2018 QPP Performance Year
March 31, 2018	2017 MIPS Submissions Due
2019	First QPP Payment Adjustments Applied

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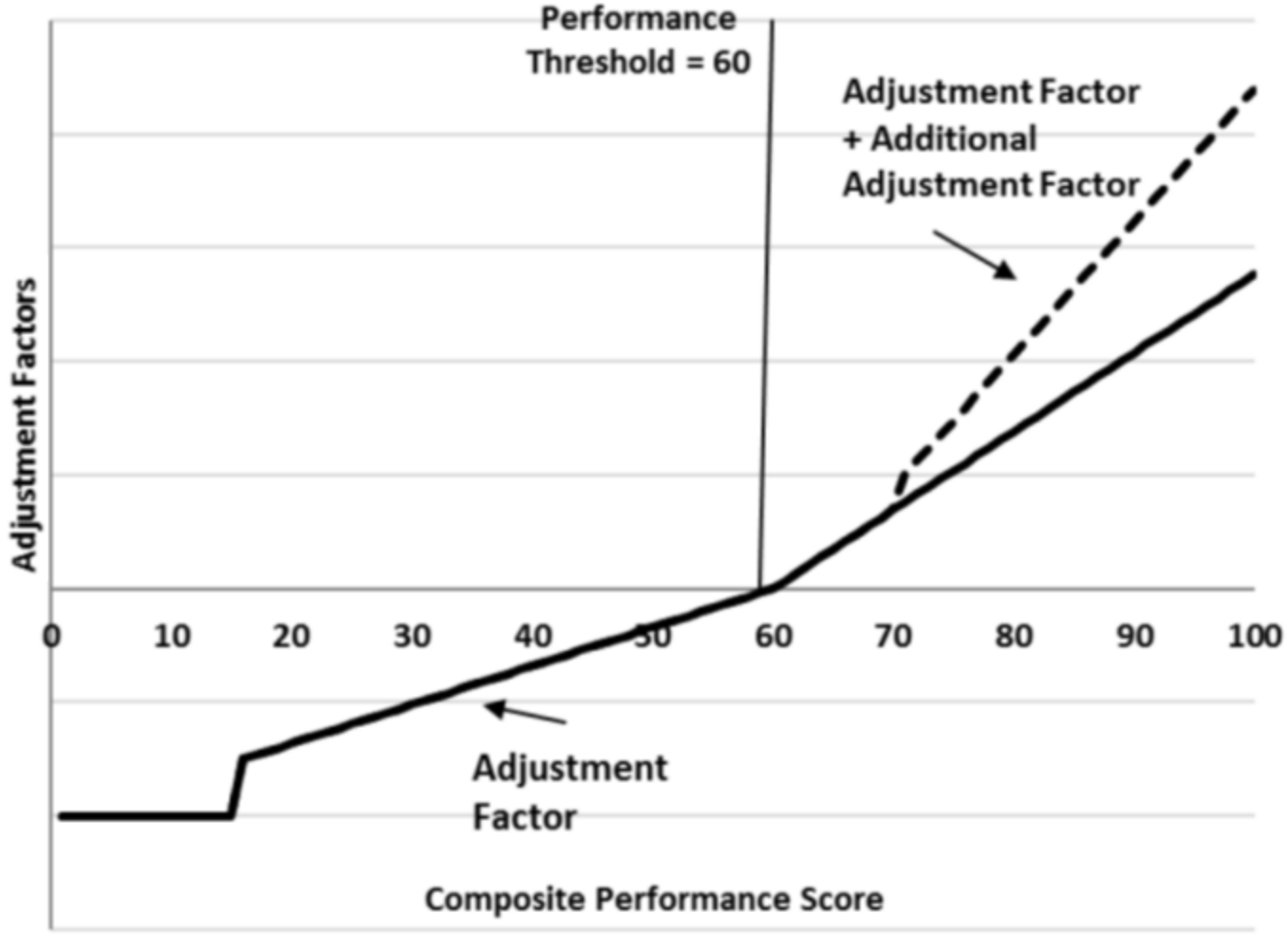
MIPS Conceptual Model



Improving the old model

1. Final (Composite) Score

   Program scores, as categories, combine into a single Final (Composite) Score

2. Continuous Variable

   Rather than Pass/Fail, the Final Score relates as a Continuous Variable to the Adjustment Factor

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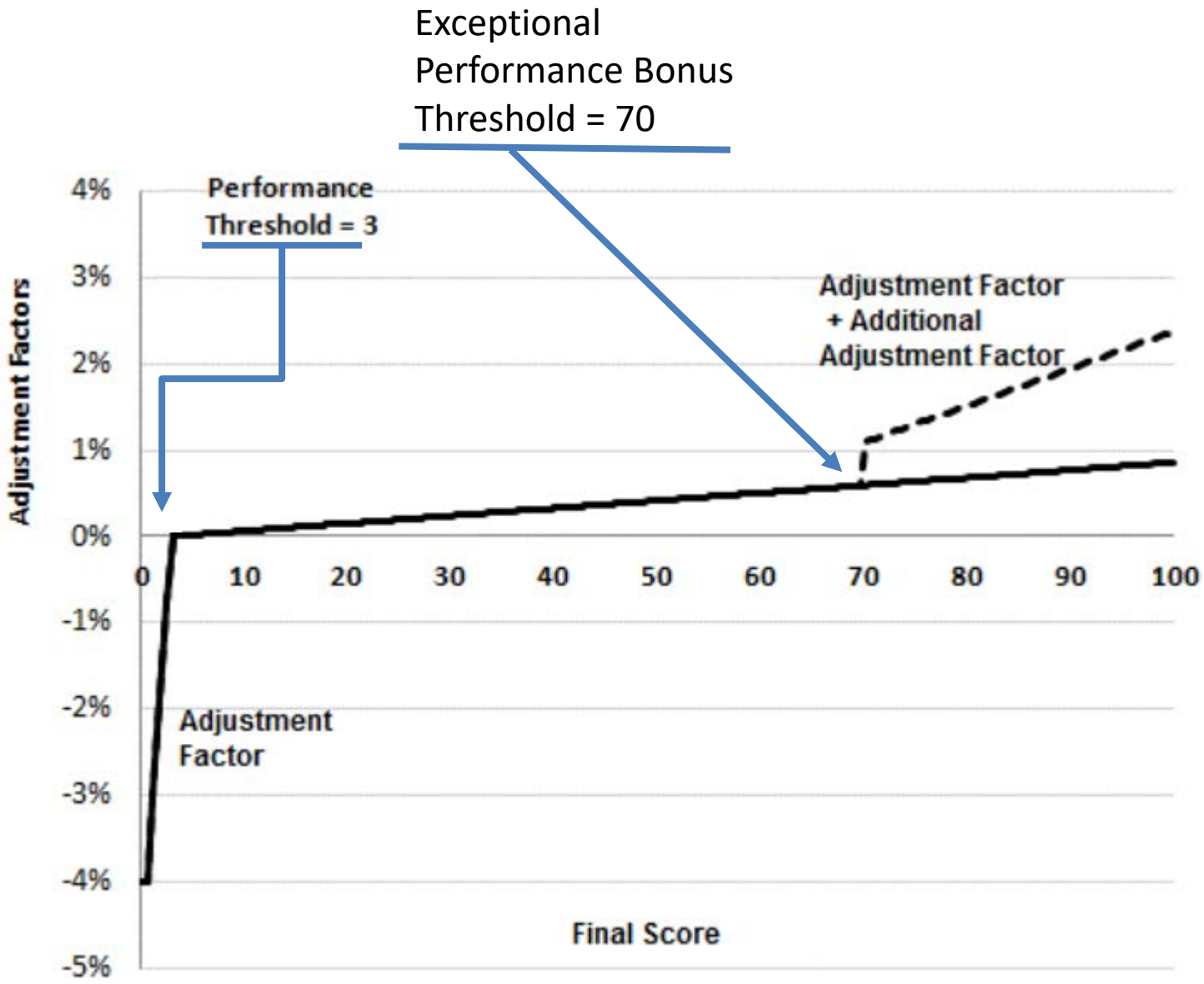
Transition Year Plan

2017 Performance Year
2019 Payment Year

<u>Pick Your Pace Options 2017</u>

- Do Nothing
- One Measure
- Some Data
- All In
- Advanced APM



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★A Second Year to Ramp Up

Build upon the iterative learning of year 1

Prepare for more robust year 3

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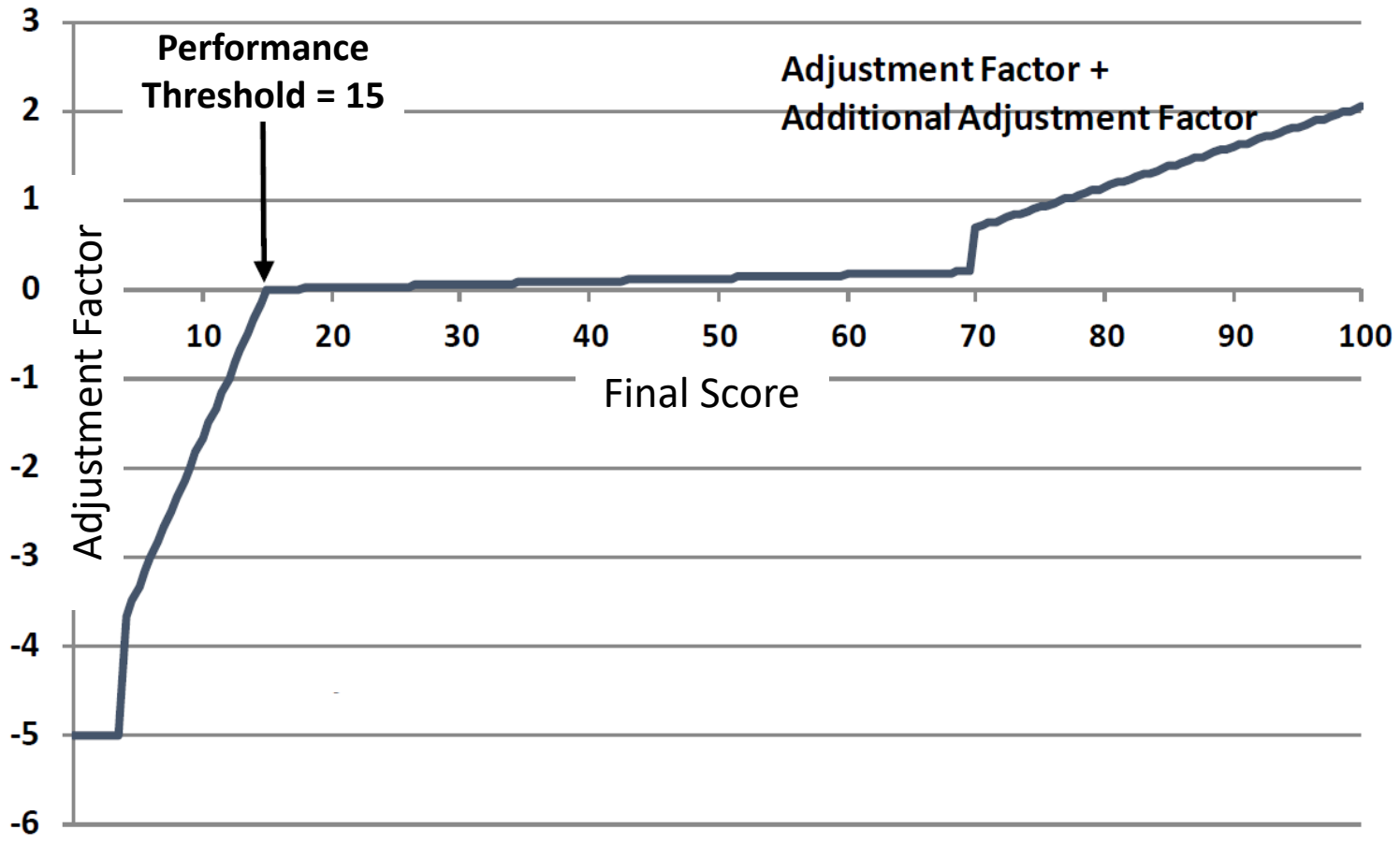
MIPS 2018

	2017	**2018**	Mature
Min Adj	-4%	**-5%**	-9%
Max Adj (estimated)	1%	**2%**	20%
Performance Threshold	3	**15**	60
Scaling Factor	< 1	**< 1**	> 1, ≤ 3
Additional Performance Threshold	70	**70**	70
Exceptional Performance Bonus	$500m 1-10%	**$500m 1-10%**	$500m 1-10%
2nd Scaling Factor	≤ 1	**≤ 1**	≤ 1
"POD" Threshold (Perf Thresh * 25%)	3	**3.75**	15



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What is the potential impact of MIPS?

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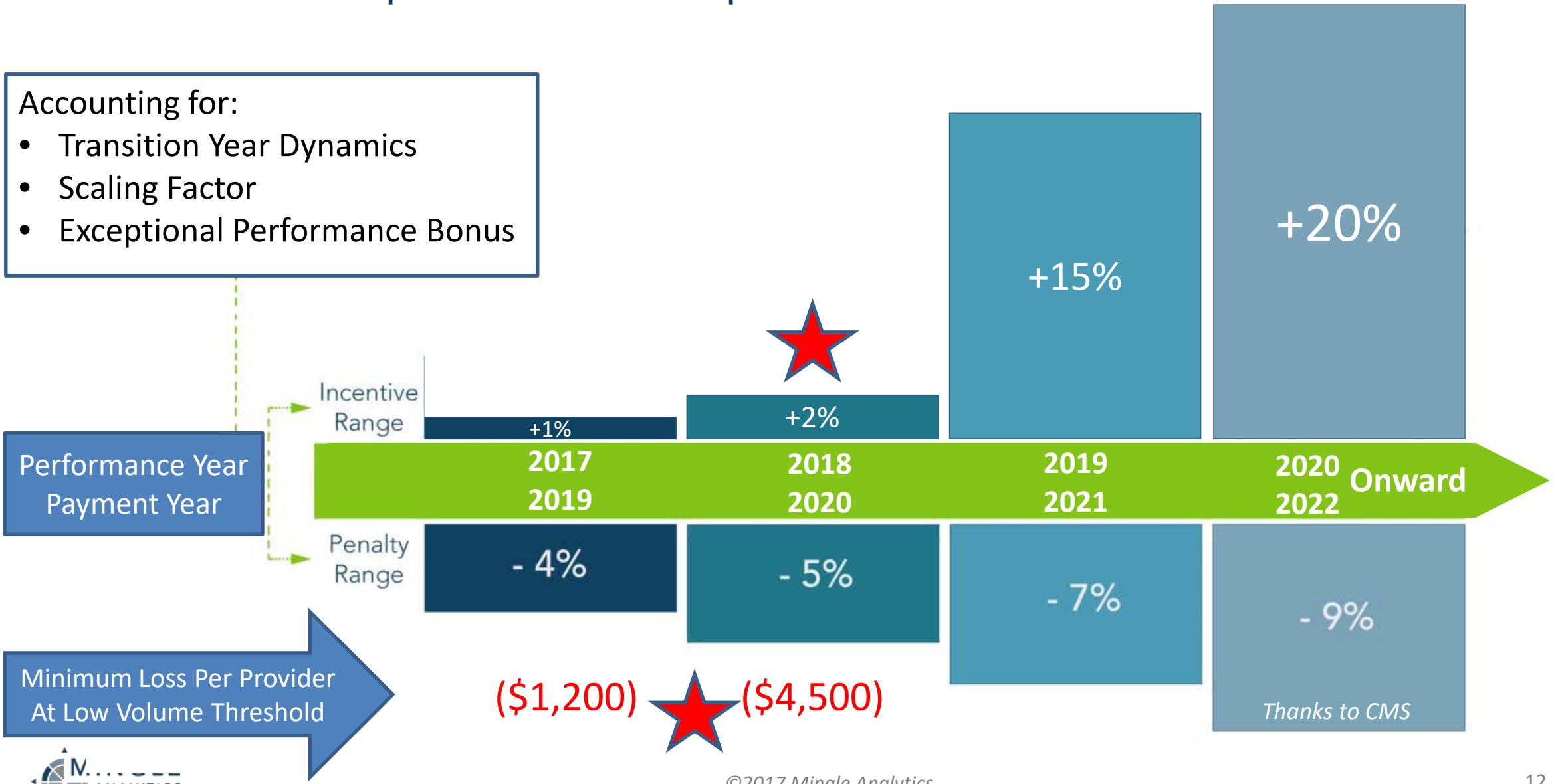
What is the potential impact of MIPS?

Accounting for:
- Transition Year Dynamics
- Scaling Factor
- Exceptional Performance Bonus



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MIPS Eligible Clinicians 2018

MIPS Eligible Clinicians

- Unique TIN/NPI
  - Physician
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Certified Registered Nurse Anesthetist
- A group that includes such clinicians

Eligible Clinicians Excluded from MIPS

- Temporary Excluded Credentials
  - Certified Nurse Midwife
  - Clinical Social Worker
  - Clinical Psychologist
  - Registered Dietician or Nutrition Professional
  - Physical or Occupational Therapist
  - Speech-Language Pathologist
  - Audiologist
- aAPM Qualified Participants (QPs)
- aAPM Partial QPs who choose not to report
- Clinicians at or below the Low Volume Threshold (when submitting individually)
- Eligible Clinicians newly enrolled with Medicare

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Low Volume Threshold

- ≤ $90,000 Medicare Allowable Charges

  (≤ $30,000 in 2017)

- OR

  ≤ 200 Part B-enrolled beneficiaries

  (≤ 100 in 2017)

- Excludes an additional 134k Clinicians
  - NOT EXCLUDED from APM
  - MAY or MAY NOT be EXCLUDED from GPRO

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Supported Submission Mechanisms and Submission Deadlines

Qualified Registry	March 31
Qualified Clinical Data Registry	
EHR/Data Submission Vendor	
Attestation (ACI and IA)	
Claims	March 1 (60d claims run-out)
Web Interface	8 week submission window between Jan 2 and March 31 TBD

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Performance Category Weights

Performance Year	Quality	Cost	Advancing Care Information	Improvement Activities
2017	60%	0%	25%	15%
2018	★ **50%**	★ **10%**	**25%**	**15%**
2019	30%	30%	25%	15%
2020	30%	30%	25%	15%

★ • Complex re-weighting protocols

★ • Hardship Exemption Applications can now apply to any/all Categories

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Performance Period Requirements

Quality	1 Full Year
Cost	1 Full Year
Advancing Care Information	90-Day minimum to 1 Full Year
Improvement Activities	90-Day minimum to 1 Full Year

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Quality Performance Category

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Quality Measure submission requirement

- 6 Measures Including 1 Outcome or High Priority Measure
  - Fewer than 6 Measures?
    - Partial credit awarded for partial submissions
    - Claims/Qualified Registry Only
      - Eligible Measure Applicability (EMA) (the new Measure Applicability Validation Test (MAV)
- Or Web Interface submission (applicable to groups ≥ 25)

- If a quality submission is made
  - 1 Administrative Claims Measure: All cause Readmissions
    - Medicare Calculates. No submission
    - Only if Group size > 15 and ≥ 200 attributed Hospitalizations

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Data Completeness

- ≥ 60% Reporting Rate Required
  - All Payer data for Reg, QCDR, EHR
  - One measure must contain data about one Medicare Patient
- Finalized the same criteria for 2019

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Expanded Measure Stratification

- Class 1 – Complete: 3-10 points
  - 60% reporting rate
  - 20 case minimum
  - Has a benchmark
- Class 2 < 20 cases or no benchmark: 3 points
- Class 3 < 60% Reporting Rate: 1 point (3 for small practices)

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Topped Out

Defined:

- Majority of clinicians near top of the distribution
  - little room to improve
  - Little basis for comparison
- 45% of measures topped out

- 4-year Topped out lifecycle
- Topped out protocols will not apply to web interface

Year

1. Identify as TOM
2. Special scoring applied
   - 7-Point Cap
3. Consider, through rulemaking, for removal
4. Removal decision made through rulemaking

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6 topped out measures selected to begin the cycle

Measure	#
Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin	21
Melanoma: Overutilization of Imaging Studies in Melanoma	224
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	23
Image Confirmation of Successful Excision of Image-Localized Breast Lesion	262
Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description	359
Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy	52

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Annual October ICD Updates

- Publish list of measures significantly affected between Oct 1 and Jan 2 as indicated by
  - 10 percent change in codes in numerator, denominator, exclusions, and exceptions
  - clinical guideline changes
  - New products or procedures
  - feedback on a measure received from measure developers and stewards
- Report only Jan 1 – Sep 30

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Cost Performance Category

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2018 Cost Category Dynamics

- 10% weight
- 2 Cost Measures
  - Total per capita costs for all attributed beneficiaries
    - Attributed to the Provider/Practice source of the Plurality of Primary Care Services
    - All Part A and Part B costs
    - 20 Case Minimum
  - Medicare Spending per Beneficiary (Inpatient)
    - Attributed to the Provider/Practice source or the Plurality of Inpatient Services
    - Costs included 30 days pre-admission to 30 days post-admission
    - 35 Case Minimum
  - NO EPISODE MEASURES

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Advancing Care Information Performance Category

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CERHT

- In the 2018 Performance Year
  - Certification Edition Requirements
    - 2014 Edition CEHRT

    Or
    - 2015 Edition CEHRT

    Or
    - Combination
  - 10 point Bonus for exclusive use of 2015
- Rule is Silent on CEHRT Requirement for 2019

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ACI Exceptions

- Hospital Based Clinicians
- Non-Patient Facing Clinicians
- ASC-Based Clinicians

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Reporting to Public Health or Clinical Data Registry

- 10 percentage points for reporting to any single public health agency or clinical data registry
- bonus score of 5 percentage points for reporting to at least one additional public health agency or clinical data registry
- The bonus registry must be different than the performance points registry

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Exclusions to Base Score Measures

- Retroactive to 2017
- Specific Exceptions to e-Prescribing and HIE Base Point Measures
  - Same minimum for any reporting period, 90-365 days
  - Generate fewer than 100 prescriptions in a reporting period
  - Generate fewer than 100 outgoing transitions of care in a reporting period
  - Receive fewer than 100 incoming transitions of care in a reporting period
    - 2015 Edition Certification only
    - applies to never-before-encountered-patients
- May choose
  - To report or not for the individual provider
  - To include data or not in the GPRO Report

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GPRO ACI

- Is the Average Reported Performance in the Group
- Group exempted from ACI only if 100% of EC are exempted
- If not exempt
  - Include in report Only providers with data in CEHRT
    - those not on CEHRT are not factored into the denominator
  - Everyone is assigned the same score

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Improvement Activities Performance Category

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Improvement Activities

- Points Doubled for
  - Non Face-to-Face
  - Small Practices (15 Providers)
  - Rural or HPSA location

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Patient Centered Medical Home

- Language adjusted to include status of “Recognized” as equivalent to “Certified”
- 50% of practice locations must be Recognized for Group to get credit
- Still worth full credit for IA
- Must attest to receive credit

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Bonus points

- Granted to extra measures that do not contribute to score
- Not considered in improvement bonus calculation

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Quality Category Improvement Bonus

- Full current year participation required
- Comparison only to previous year data
  - If previous year Quality score ≤ 30%, then 30% is used as comparison
  - Will convert data for comparison if entities do not match
- Calculated as
  - Category Percentage Scores without Bonus Points
  - 10%*(ThisYr-LastYr)/LastYr
- Can only be positive
- Capped at 10 percentage points

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Cost Category Improvement Bonus

- Measure level analysis
- Must have data in prior year
  - Same measure
  - Same entity level
  - Both sets Meet data sufficiency minimums
- Can only be positive
- Max of 1 out of 100 possible cost points
- Cost improvement Score = ((measures with significant improvement – measures with significant decline) / measures) * 1 percentage point
- (Cost Achievement Points/Available Cost Achievement Points) + (Cost Improvement Score) = (Cost Performance Category Percent Score)

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New Bonuses

- Improvement
  - Quality: applies to category-level improvement
  - Cost: Applies to measure level improvement
- Applies at Final Score level
  - 5-Point Small practice bonus (≤ 15 clinicians)
  - 5-Point complex patient bonus (dual eligibility ratio AND HCC risk score)
    - Based on Risk Score year prior to performance year
    - Patient attribution overlapping performance year (Sept-Aug)

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10 ACI Bonus Points for IA involving CEHRT

- Additional IA approved
- 30 CEHRT IA Measures Available

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Electronic Flow Bonus

- Limit to 10% of Denominator
- Scoped for first 2 years only
- All but Claims Submission Mechanism

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Special Provider Populations

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Virtual Groups

- Small Practices (≤ 10 EC) may combine as a Virtual Group
- 2 stages
  - Stage 1, optional: Request eligibility determination from Technical Assistance
  - Stage 2, required: Self nomination to CMS
    - 2018 application due December 31, 2017
    - December 1 in subsequent years
- Must have written agreement
- Subject to yearly renewal
- Irrevocable status for the year

- Consider for:
  - 25 providers can report through Web Interface, Abstract 248 charts per measure
  - Integrated Delivery Networks
  - Independent Practice Associations where
    - Resources are shared (EHR, PMS)
    - Care for a common patient population

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Automatic Identification

CMS is now automatically identifying the following statuses with access through qpp.cms.gov:

- Low Volume
- Small Practices
- Rural and HPSA Clinicians and Practices
- Non-Patient Facing Clinicians and Practices
- Hospital Based Clinicians and Practices
- Ambulatory Surgical Center Based Clinicians and Practices
- Facility-Based Clinicians and Practices
- Extreme and Uncontrollable Circumstances

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Low Volume Threshold

- ≤ $90,000 Medicare Allowable Charges

OR

- ≤ 200 Part B-enrolled beneficiaries
  - Excludes an additional 134k Clinicians
  - 2 Low Volume Determination Periods
    - Each period Sept 1 – Aug 31 with 30-day claims run out
    - 1st period ending in the calendar year 2 years prior to performance year
    - 2nd period ending in the calendar year 1 year prior to performance year

Applicable to:

- MIPS Eligibility
  - Applied at the submitting entity level: individual, GPRO TIN
  - Same thresholds apply for each group

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Small Practices

≤ 15 Eligible Clinicians

- Determined from claims data
  - Count of Part B Billing Clinicians, not just MIPS-eligible
  - Count effected by part time and locum tenens staff
- 12-month Small practice size determination period
  - Sept 1 – Aug 31 with 30-day claims run out
  - ending in the calendar year prior to performance year

Applicable to:

- Eligibility for Technical Assistance
- Improvement Activity Requirement
- ACI hardship exception
- Small Practice Bonus
- Low Volume Exclusion advanced to ≤ $90k or 200 patients
- Virtual Groups (≤ 10 Eligible Clinicians)
- 3 Point floor on Quality Measures

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Rural and HPSA Clinicians and Practices

- Determined from PECOS practice location zip code
  - Rural = Zip designated in the Health Resources and Services Administration (HRSA) Area Health Resource data set
  - HPSA = Zip designated by section 332(a)(1)(A) of the Public Health Service Act
- TIN or Virtual Group with > 75% of NPIs billing from a Rural or HPSA location

Applicable to:

- Improvement Activity Points doubled per activity

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Non-Patient Facing Clinicians

- Defined as NPI who Bills ≤ 100 Patient-Facing encounters (Part B)
- Group or Virtual Group where > 75% of NPIs meet definition
- Annual publication of Patient-Facing CPT codes
- 2 Non-Patient Facing Determination Periods
  - Each period Sept 1 – Aug 31 with 30-day claims run out
  - 1st period ending in the calendar year 2 years prior to performance year
  - 2nd period ending in the calendar year 1 year prior to performance year

Applicable to:

- Improvement Activity Points doubled per activity
- Advancing Care Information (ACI)
  - Automatically reweighted to 0
  - Scored if Submitted

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Hospital-Based Clinicians

- Defined as NPI who Bills ≥ 75% of services at POS **19**, 21, 22, 23
- Group or Virtual Group where > 75% of NPIs meet definition
- 12-month hospital based determination period
  - Sept 1 – Aug 31 with 30-day claims run out
  - ending in the calendar year prior to performance year
  - In case of multiple affiliations, use plurality of Medicare beneficiaries

Applicable to:

- Advancing Care Information (ACI)
  - Automatically reweighted to 0
  - Scored if Submitted

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Ambulatory Surgical Center (ASC) Based Clinicians

- Defined as NPI who Bills ≥ 75% of services at POS 24
- Group or Virtual Group where > 75% of NPIs meet definition
- 12-month ASC based determination period
  - Sept 1 – Aug 31 with 30-day claims run out
  - ending in the calendar year prior to performance year

Applicable to:

- Advancing Care Information (ACI)
  - Automatically reweighted to 0
  - Scored if Submitted

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Facility-Based Clinicians

- Defined as NPI who Bills ≥ 75% of services at POS 21 or 23
- Group or Virtual Group where > 75% of NPIs meet definition
- 12-month facility based determination period
  - Sept 1 – Aug 31 with 30-day claims run out
  - ending in the calendar year prior to performance year
  - In case of multiple affiliations, use plurality of Medicare beneficiaries

Applicable to:

- Ability to choose Hospital Value Based Purchasing Program Quality and Cost Measures for MIPS
- Expected to be applicable for 2019 Performance Year

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Facility Based Measurement Available in 2019

- Based on Hospital VBP program
- 2019 HVBP Program year for 2021 MIPS payment year
- Applies to Cost and Quality
- Individuals with 75% of service at POS 21, 23
- Groups where 75% of individuals qualify as above
- 1-year facility based determination period 9-1 through 8-31 ending yr prior to perf yr
- In case of multiple hospital affiliations, use hospital with plurality of medicare beneficiaries
- In case of equal plurality, use best score
- Elect this option through the portal during the submission period

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Ambulatory Surgical Centers (ASCs)
Home Health Agencies (HHAs)
Hospice
Hospital Outpatient Departments (HOPDs)

Items Billed under facility's all-inclusive payment methodology	Adjustments do not apply
Items Attributed to NPI and billed per PFS	Adjustments apply

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Critical Access Hospitals

	Clinician Charges	Facility Fees
Method I Billing	Adjustments Apply	Do not apply
Method II, billing rights not assigned to Group	Adjustments Apply	Do not apply
Method II, billing rights assigned to Group	Adjustments Apply	Adjustments Apply

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Federally Qualified Health Centers
Rural Health Centers

- Cost based reimbursement is not subject to MIPS
- Medicare Part B charges through Physician Fee Schedule are subject to MIPS

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Significant Hardship Exceptions

- **Due by December 31 starting in 2017**
- Applicable to Individuals, Groups, Virtual Groups
- Expanded to apply to any one or more performance categories
- Results in Re-Weighting
- < 2 Performance Categories → Final Score at Performance Threshold
- 5 year limitation removed
- **Automatic Extreme and Uncontrollable Circumstance Policy**
  - Interim (emergency) final rule
  - "The Hurricanes Harvey, Irma, and Maria Rule"
  - Final Score = Performance Threshold
- Data accepted and scored if submitted

Supported Reasons for Approval Include:

- Significant hardship for small practices
- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT
- Lack of face-to-face patient interaction
- Decertified EHR Technology
  - Good Faith Effort to Migrate to CEHRT
  - Annual Renewal limited to 5 years

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Multiple Submission Mechanisms Will be an option starting in 2019

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New Scoring Language

- Measure Achievement Points
- Total Measure Achievement Points
- Measure Bonus Points
- Total Measure Bonus Points
- Total Available Measure Achievement Points
- Scoring equation
  - (TMAP+ TMBP) / TAMAP = Total Quality Performance Category Score
  - Quality Performance Category Percent Score when expressed as a percent

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CAHPS for MIPS

- Voluntary option for groups
  - CAHPS for ACOs required for ACOs
- Must use an approved survey vendor
- Counts for
  - 1 quality measure
  - 1 Patient experience measure (2 bonus points)
  - 1 High Priority Measure
- Survey Period is minimum of 8 weeks between Nov 1 and Feb 28
- Must self-nominate by June 30 of Performance Year

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Clarifications/Corrections

- Meaningful user = any provider with an ACI Category Score ≥ 75%
- Timely for Patient Access = 4 Business Days after data available to EC
- Applied Retroactively to 2017
  - View, Download, and Transmit (VDT) action previously attributed to Patient is corrected to be attributed to Provider
  - Summary of Care document can be generated by any support staff, not just clinician
  - Corrections to Syndromic Surveillance Measure to be consistent with current version
  - Verbiage corrections to: Patient Access, Patient Education, Health Information Exchange, & Medication Reconciliation

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Thank You

Ask your questions now or
send by email to daniel.mingle@mingleanalytics.com

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Reduce your Risk of Penalty

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Q&A

Rosalind asks:

Can you please address if there is anything different for Critical Access Hospitals?

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Q&A

Ted asks:

How do you see more patient reported outcomes being included over the next few years?

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Q&A

Kristi Asks:

What are the differences in the 2017 and 2018 requirements. Do we have a Meaningful Use segment? Practices in the CPC+ are considered QPs and exempt from MIPS reporting; therefore, what do we have to submit--anything? Thank you.

Plain English--whew

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Q&A

Catherine Asks:

How can we prepare the cost part of the MIPS in 2018?

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Q&A

Genevieve Asks:

Will those in hurricane-affected areas get something from Medicare stating that they are exempt or should they just assume that they are exempt because they are in an affected area?

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Q&A

Beth Asks:

Does MIPS apply to physical therapists?

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Q&A

Robert Asks:

It seems too easy to qualify for the minimum requirements for 2017 to stay out of the penalty category. What is the minimum a group must do to not get a penalty in 2019?

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Q&A

Elizabeth Asks:

How do you help providers to identify/report on "Improvement Activities" and "Advancing Care Information Measures"?

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Q&A

Vicki asks:

What are the requirements for non-patient facing providers?

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Q&A

Mary Jean Asks:

Please provide any information of "virtual" groups - how are they forming, how is the reporting expected to be done?

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