MINGLE ANALYTICS

Starting at
Noon EDT
July 25, 2018

Diving into the 2019 Proposed Rule & the future of MIPS

Dr. Dan Mingle

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http://mingleanalytics.com/webinars

MINGLE ANALYTICS

Agenda

- Proposed changes to 2019 quality reporting
- Potential impact on your practice
- Your opportunity to comment

Physician Quality Reporting System
PQRS

Value Modifier
VM

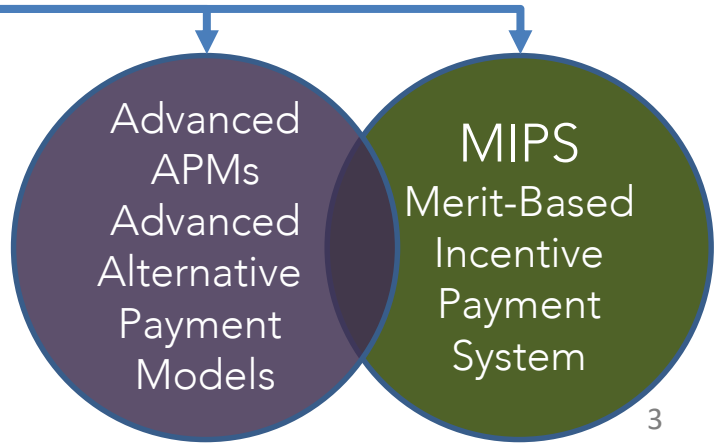
EHR Incentive Program
MU (meaningful use)

Medicare Access and CHIP Reauthorization Act
MACRA

Modified By
Bipartisan Budget Act of 2018

Modified By
Annual Rulemaking 2019

Quality Payment Program
QPP



MINGLE ANALYTICS

Priorities for 2019

- Reduce clinician burden
- Retire topped out process measures
- Fund new quality measure development
- New episode-based cost measures
  - Even to be included in 2019
- Implement “Meaningful Measures Initiative”
- Change EHR emphasis to “Promoting Interoperability”
- Support of small and rural practices
- Implement “Patients over Paperwork Initiative”
- Promote Price Transparency
- Implement “MyHealthEData Initiative”

About the Bipartisan Budget Act of 2018

- Allowing 3 additional transition years
  - More flexibility on Cost
    - min 10
    - max 30
  - Performance threshold flexibility
- Applies adjustments only to covered professional services beginning in 2019 payment year
  - Increased low volume exclusions
  - Lower penalty pool
  - Lower basis for incentive (and penalty)
- Low volume threshold, starting in 2018 performance period,
  - charges and number of lines refer only to covered professional services

MyHealthEData Initiative

- Announced by CMS Administrator Seema Verma
- At HIMSS 2018
- To empower patients by
- ensuring that they control their healthcare data
- can decide how their data is going to be used
- while keeping that information safe and secure
- break down barriers that prevent patients from having electronic access and true control
- from the device or application of their choice

Executive Order Promoting Healthcare Choice and Competition Across the United States (Oct 2017)

- Changing the rate of growth of healthcare spending
- To foster competition in healthcare markets
- To support these goals, we are
  - helping patients control their health data
  - make it easier to take their data with them
  - move in and out of the healthcare system
  - make informed choices about their care
  - leading to more competition and lower costs

The Pertinent Details

2019 Rulemaking Timeline

- Available July 12, 2018 in Federal Register in “unpublished PDF” format
- Part of the annual “…**Revisions to Payment Policies under the Physician Fee Schedule…”**
- Scheduled for formal “publication” on July 27, 2018
- **60-day comment period closes 5PM on September 10, 2018**
- Final Rule to be published on November 1, 2018
- The 2019 Rule effects:
  - 2019 Performance Year eligibility, reporting, and scoring
  - 2021 Payment year adjustments

60-day comment period closes at 5PM on September 10, 2018

- Submission options
- Electronically through **http://www.regulations.gov**
- Regular mail
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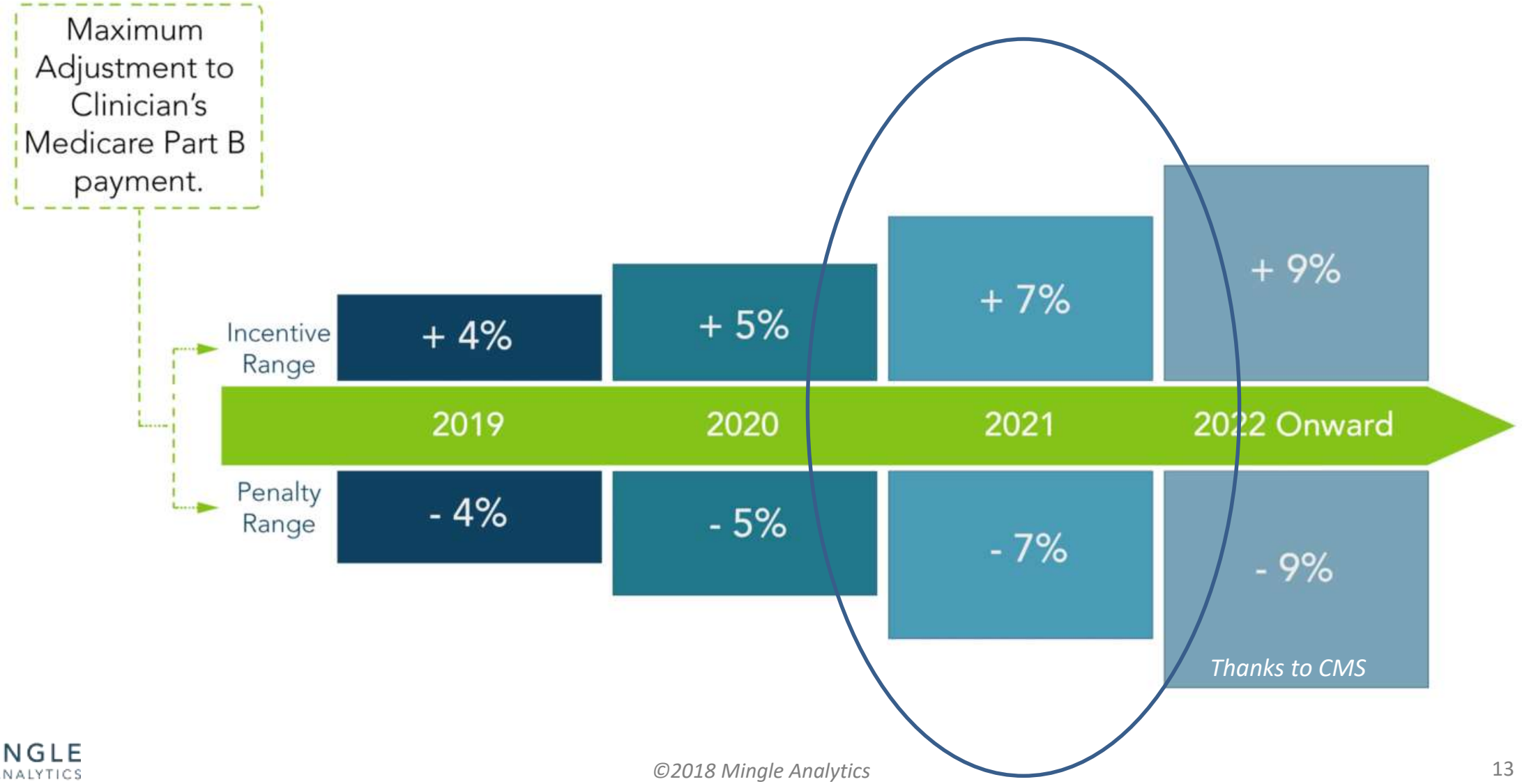
MIPS Performance Year 2017

- 91% of Eligible Providers Submitted Data
- Year 1 Feedback Reports are Available
  - Access it through the QPP Portal
  - Use your EIDM Credentials
- Maximum Incentive @ Final score of 100 = 2.02%

Another Step Toward Maturity

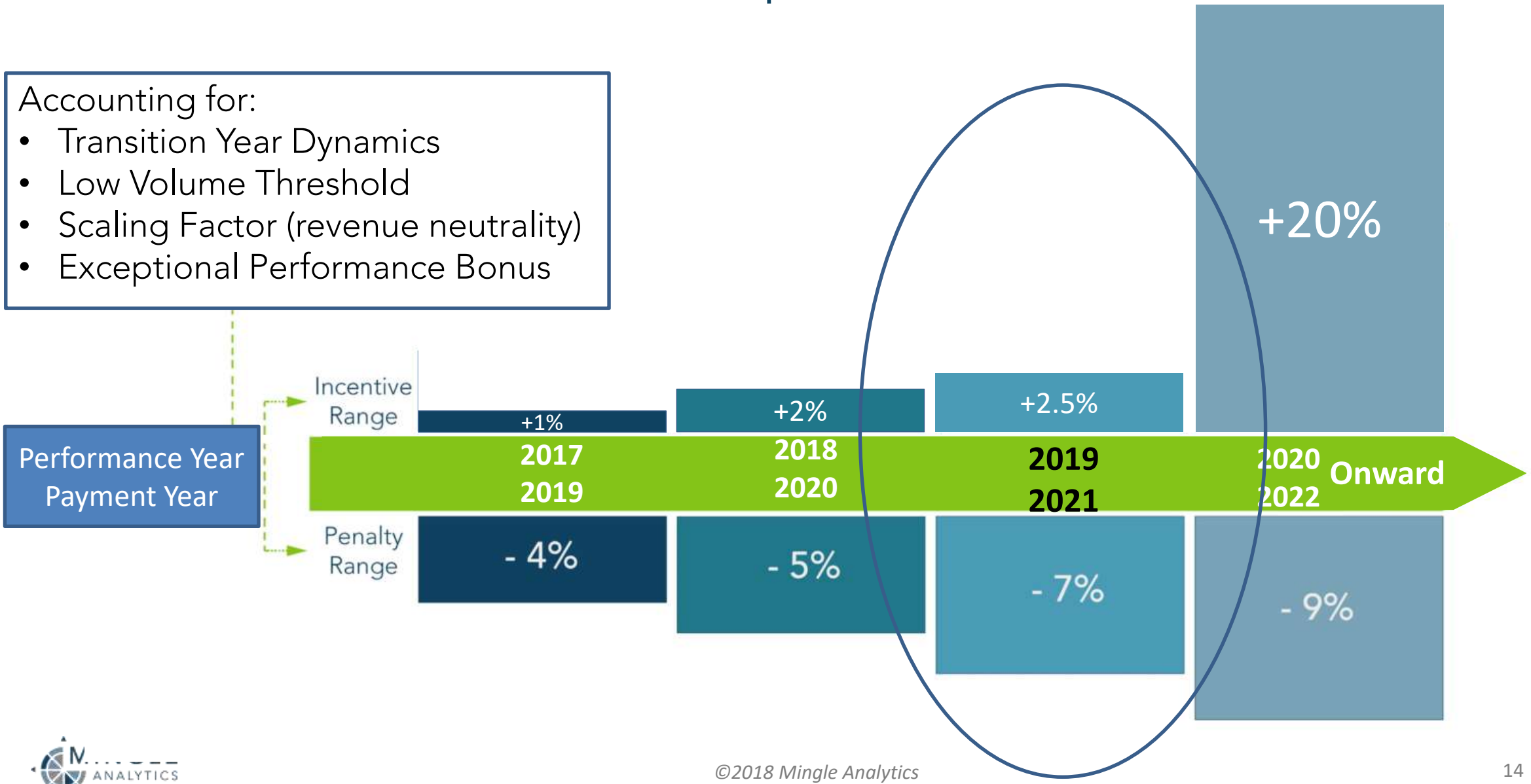
- Adjustment ±5% → ± 7%
- Penalty for non-participation -5% → -7%
- Threshold to avoid the penalty: 15 →30 Points
- Threshold for exceptional performance bonus: 70 → 80 points

What is at Stake (Theoretical)

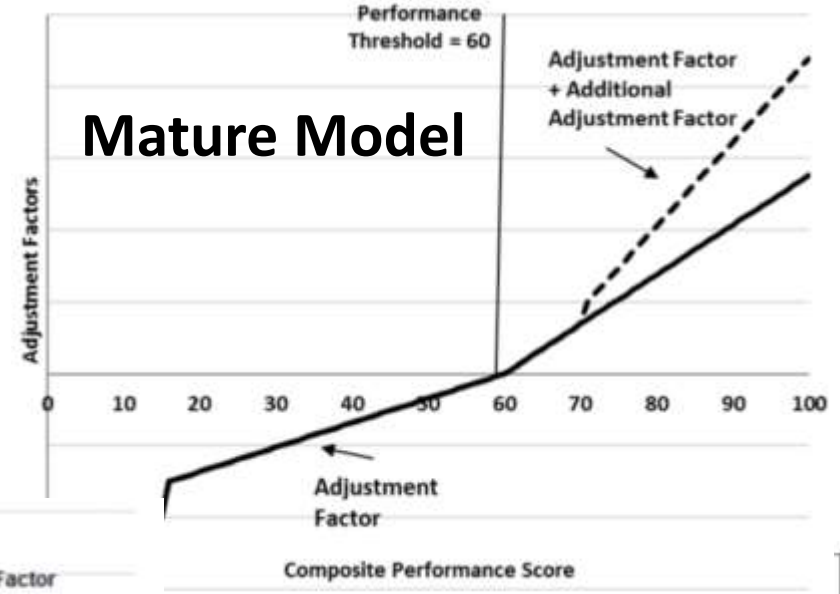


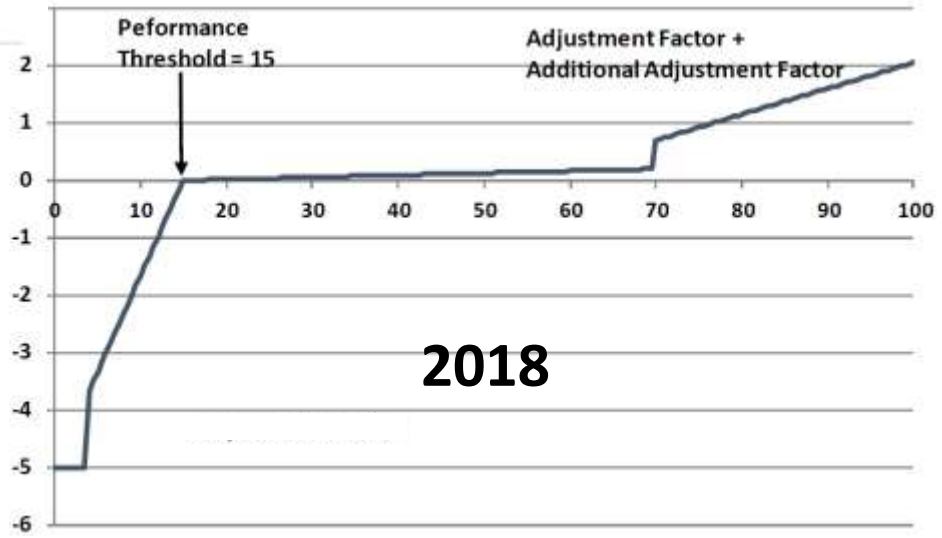
What is at Stake (Proposed)

Accounting for:
- Transition Year Dynamics
- Low Volume Threshold
- Scaling Factor (revenue neutrality)
- Exceptional Performance Bonus



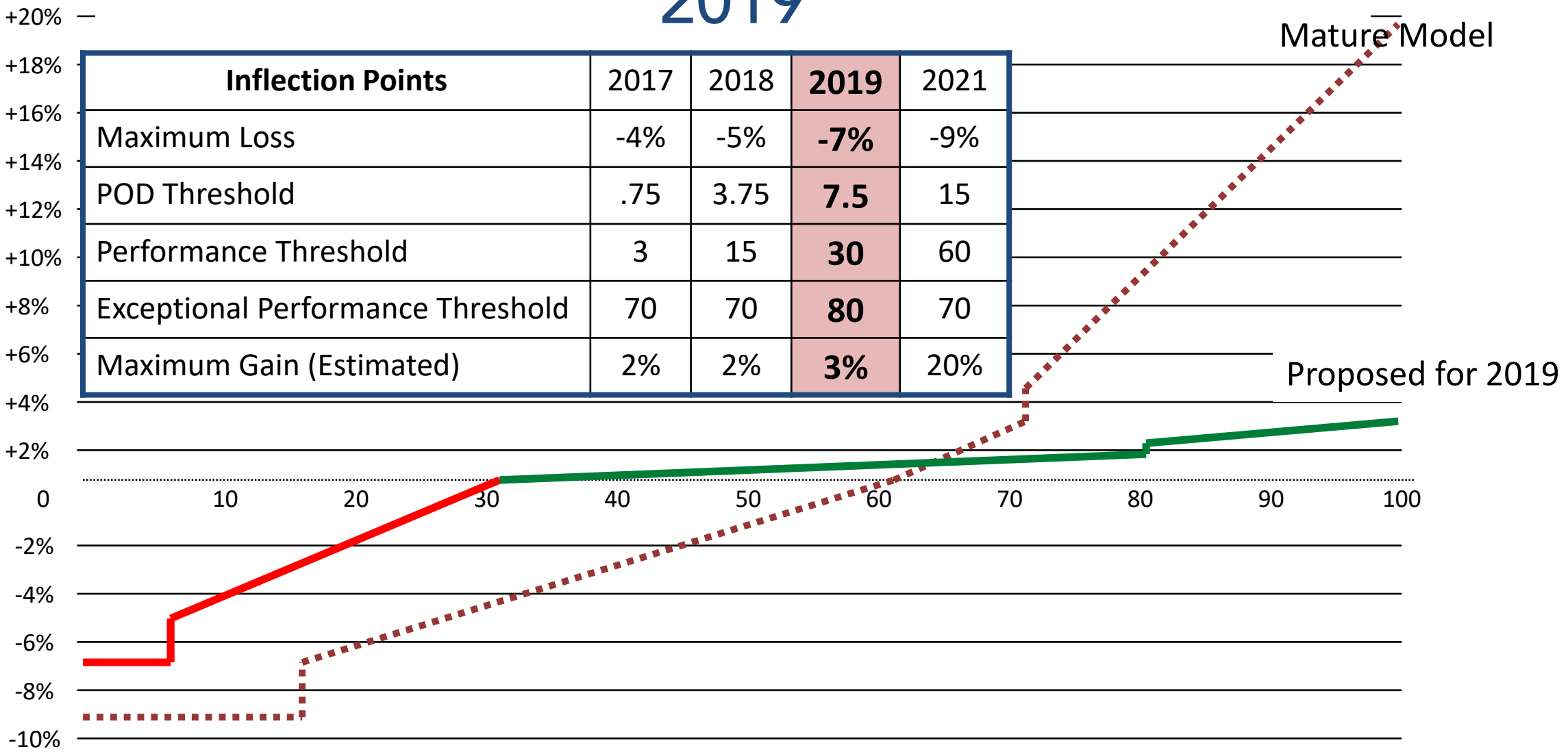
Historically & Graphically





Relationship of Final Score to Adjustment 2019

Inflection Points	2017	2018	**2019**	2021
Maximum Loss	-4%	-5%	**-7%**	-9%
POD Threshold	.75	3.75	**7.5**	15
Performance Threshold	3	15	**30**	60
Exceptional Performance Threshold	70	70	**80**	70
Maximum Gain (Estimated)	2%	2%	**3%**	20%



Eligibility

Eligible Clinicians – Proposed 2019

MIPS Eligible by Credentials* aka "Provider Type"

Physicians*

Doctors of:

- Chiropracty
- Dental Medicine
- Dental Surgery
- Medicine
- Optometry
- Osteopathy
- Podiatric Medicine

Non-Physicians*

- Certified Registered Nurse Anesthetist (CRNA)
- Clinical Nurse Specialist (CNS)
- Nurse Practitioner (NP)
- Physician Assistant (PA)

New for 2019

- Clinical Psychologist
- Clinical Social Worker
- Physical Therapist
- Occupational Therapist

Still Ineligible

- Registered Dietician or Nutrition Professional
- Speech-Language Pathologist
- Audiologist
- Certified Nurse Midwife

Not enough measures
Might reconsider if measure removals not all ratified

Who is eligible?
Based on LOW VOLUME

EXCLUDED	INCLUDED
≤ $90,000 in Medicare Part B OR ≤ 200 Medicare Part B patients OR ≤ 200 Medicare Part B services	>$90,000 in Medicare Part B AND >200 Medicare Part B patients AND >200 Medicare Part B services

Opt-in Proposal

- Any clinician or group may opt in if
  - MIPS Eligible
  - Qualifies for Low Volume Threshold by < 3 criteria
  - Make irrevocable election in QPP Portal
    - Applies to individuals, groups, and virtual groups
    - MIPS APM entity may opt in. Participants must stay with the entity
    - When must the election be made?

- Estimate
  - 3rd criterion @ 200 services will exclude no more clinicians
  - 19,621 eligible to opt in without third criteria
  - 42,025 eligible to opt in at 200 services criteria
  - 50,260 eligible to opt in at 100 services criteria

Still intending to align due dates for all submissions Including Web Interface

Deadline extended

- If March 31 falls on a weekend
- If significant downtime experienced

Single "MIPS Determination Period"

- For all determination of eligibility and special status:
  - Low-volume
  - Non-patient facing
  - Hospital based
  - Small practice
  - ASC-based
- First 12-month segment:
  - Oct. 1, 2017 to Sept. 30, 2018
  - including a 30-day claims run out
- Second 12-month segment:
  - Oct. 1, 2018 to Sept. 30, 2019
  - does not include a 30-day claims run out

Proposed Performance Period and Weighting

Category	Performance Period	Weight
Quality	Full Year	45%
Cost	Full Year	15%
Promoting Interoperability	90 – 365 days	25%
Improvement Activities	90 – 365 days	15%

New Terminology

- Collection type:
  - MIPS CQMs (pka Registry Measures)
  - eCQMs
  - QCDR Measures
  - CMS Web Interface measures
  - CAHPS Survey measure
  - Administrative Claims
- Submitter Type
  - Group
  - Individual
  - Third Party Intermediary
- Submission Type
  - Direct
  - Log in and upload
  - Log and attest
  - Medicare Part B Claims
  - CMS Web Interface

Quality Performance Category

Quality

- Theme: Primarily the same, influenced by Meaningful Measures Initiative
- Weight 45%
- Completeness Criteria to remain 60%
- Case Minimum to remain 20
- Still six measures, 1 outcome or high-priority
- Still three classes of measures
  - Class 1, All In: 3-10 points
  - Class 2, Lacks Benchmark or Cases < 20: Points
  - Class 3, token effort
    - 1 Point
    - 3 Points for Small Practices
- Bonus points,
  - End to End Electronic capped at 10% of denominator
  - Extra High Priority Measures capped at 10% of denominator
  - Small Practice Bonus to apply to Quality instead of Final Score
- Improvement bonus stays the same

Meaningful Measures Initiative Intentions of

CMS committed to

- assessing only issues core to
  - providing high-quality care
  - Improving patient outcomes
- focusing on
  - outcome-based measures
  - reducing unnecessary burden on providers
  - putting patients first

- Align across Programs
- Drive Change

Thereby

- Eliminating disparities
- Tracking measurable outcomes and impact
- Measure the things that matter most to practices and patients
- Safeguarding public health
- Achieving cost savings
- Improving access for rural communities
- Reducing burden

Changes to Measures for 2019

- 10 new MIPS quality measures
  - 4 patient reported outcome measures
  - 7 high priority measures
  - 1 measure that replaces an existing measure
  - 2 within MM framework
- Retire 34 quality measures
- Opioid-related measures are now high-priority

Potential Impact of Measure Changes

- Many "popular measures" being removed
  - Affect 137 Mingle practices
  - Some practices reporting as many as 3 of the ones proposed for removal
  - Pathology most affected with 99 and 100 scheduled for removal

Meaningful Measures & Web Interface

- 6 Measures proposed for removal (see table)
- Propose to add
  - ACO-47 (NQF #0101) Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls.
- Consider extending Web Interface use to Groups ≥ 16

#	Measures Proposed for Removal
46	Medication Reconciliation Post-Discharge
111	Pneumococcal Vaccination Status for Older Adults
117	Diabetes: Eye Exam
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
318	Falls: Screening for Future Fall Risk

Topped Out Measures

- If a measure is topped-out
  - it's not driving improvement
  - it's become a Standard of Care
- Unchanged
  - 4-year lifecycle for identification and removal
  - Scoring cap of 7 points
  - Policies do not apply to
    - CMS Web Interface measures
    - CAHPS for MIPS Summary Survey Measures
- Consider Fast Track removal in 1 year for topped out process measures

Implement Facility Based Scoring

- Individuals attributed to hospital with plurality of Medicare patients
- Facility-Based Group
  Where ≥ 75% of MIPS Eligible Clinicians individually qualify as Facility-Based Group attributed to hospital with plurality of their individual clinicians
- the measure set for the fiscal year Hospital Value-Based Purchasing (VBP) program that begins during the applicable MIPS performance period will be used
- Automatically applied to individuals if Cost/Quality scoring beneficial – no other submission requirements
- Group: Must submit either Group IA or PI to qualify for Group FBS
- If the attributed hospital does not have a facility score for the year, NPI or TIN must participate in MIPS with another method

Other Quality Changes

- Claims submissions limited to clinicians in "small" practices
- Small practice bonus now added to Quality instead of Final Score
- Register for CAHPS and don't meet the CAHPS case minimum
  - Only 5 measures required (reduce denominator to 60 →50)
- Can submit measures from multiple mechanisms and CMS will score across mechanisms
- Consider Gold-Silver-Bronze Tiering of Quality Measures

Cost

- 15% Weight
- Total Per Capita Cost (TPCC)
- Medicare Spending Per Beneficiary (MSPB)
- 8 new episode-based measures
  - 10 case minimum for 5 procedures measures
    - Attribution to each clinician who renders trigger service
  - 20 case minimum for 3 inpatient medical condition measures
    - Attribution to each clinician who bills in the episode
    - Where the billing TIN renders ≥ 30% of E&M claim lines

Episode Measures for 2019

Measure Topic	Measure Type
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural
Knee Arthroplasty	Procedural
Revascularization for Lower Extremity Chronic Critical Limb ischemia	Procedural
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural
Screening/Surveillance Colonoscopy	Procedural
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition
Simple Pneumonia with Hospitalization	Acute inpatient medical condition
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition

Improvement Activities

- 15% of Final Score
- Theme of changes to improvement activities
  - Trying to make descriptions and activities more inclusive of specialists
- Removing 5 activities, Adding 6
- Removal IA that earn bonus for PI use
  - "Not an effective way to emphasize CEHRT"
- Seeking Comments on Concept of Multi-Category Measures

  Send Summary of Care,

  Closing Referral Loop– IA and Closing Referral Loop Quality

Promoting Interoperability

- Theme—Name change says it all
- 25% of Final Score
- Must use 2015 CEHRT
- Still 90-365 days
- Reweighting the same and includes new clinicians
- Scoring revamped, performance based
- Measures dropped
- Measures added

Security Risk Assessment is a minimum requirement to receive any points

Sole remaining Base Measure

No Score attached

Scoring Changes

- Security Risk Assessment is a minimum requirement to receive any points
- Scores for measure are added for up to 100 points.
- All measures are mandatory unless exclusions
  - Exclusions are no longer a "free pass"
  - **If exclusions are claimed, the points are reallocated to other measures.**
- PI will be aligned with the Hospital/CAH requirements to reduce reporting burden.

TABLE 36: Proposed Scoring Methodology for the MIPS Performance Period in 2019

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	10 points
	Bonus: Query of Prescription Drug Monitoring Program (PDMP)	5 points bonus
	Bonus: Verify Opioid Treatment Agreement	5 points bonus
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Choose two of the following: Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10 points

Bonus Points

- Retain: Care of Complex Patients in the Final Score
- Retain: End to End Electronic Reporting
- Move: Small Practice bonus to Quality Performance Category
  - 3 points added if data submitted on ≥ 1 quality measure
- Remove: CMS Web Interface Reporters do not get High Priority Bonus
- Table: Quality and Cost Improvement bonuses will not apply until 2024 payment year

Advanced Alternative Payment Models

Advanced Alternative Payment Models

- Implement All-Payer option as planned
- aAPM participant CEHRT usage threshold at 75% (50%)
  - Other Payer aAPM must have 75% in 2020 (starts at 50%)
  - Either Other Payer or Clinician may provide evidence of utilization
- Revenue-based nominal amount standard continues at 8% through performance year 2024
- Multi-year (duration of agreement) eligibility for Other-Payer aAPM
- Expand QP determination to include TIN level option
- Partial QP to declare and commit to MIPS

Intriguing things in the PFS

Modernizing Medicine

- Expanding traditional "telehealth" visits to recognize technology-based services
- Support non-visit care using telecommunications technology by: paying clinicians for virtual check-ins – brief,
  - non-face-to-face appointments via communications technology; paying clinicians for evaluation
  - of patient-submitted photos;
  - expanding Medicare-covered telehealth services to include prolonged preventive services.
- Coding changes to remove duplication of entries

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Q&A

Paula asks:

What does “topped out” mean in reference to measures?

Q&A

Jennifer asks:

How, and when, do I opt out of MIPS with an exemption?

Q&A

Sylvia asks:

I am particularly interested in the new flexible for facility-based clinicians to use facility info with no submission required.

What are the pitfalls for a practice to do this?

Q&A

Maryellen asks:

Is 2015 CEHRT required in 2019?

Q&A

Mande asks:

Can you review changes to MU Stage 3 and MIPS-PI 2019?

Q&A

Lydia asks:

Is the low-volume threshold of < $90,000 or < 200 patients changed in year 3?

Q&A

Basman asks:

We are a group of mental health providers in a private practice and are a client of Mingle analytics. Can you discuss mental health specifically psychology and social work participation in 2019?