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CMS Final Rule for The Merit-Based Incentive Payment Program Performance Year 2019

Presented by Dr. Dan Mingle

Agenda

- Orientation
- Reflections on 2017 / Estimates for 2019
- Highlights from the final rule for performance year 2019
- Important Details
- The Rhetoric Behind the Rules
- Q&A

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Stay Tuned

- Focused Presentation on important Physician Fee Schedule Changes
- We'll present on Alternative Payment Models after release of the "Pathways to Success" Final Rule

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Physician Quality Reporting System
PQRS

Value Modifier
VM

EHR Incentive Program
MU (meaningful use)

Medicare Access and CHIP Reauthorization Act
MACRA

Quality Payment Program
QPP

APMs
Alternative Payment Models

MIPS
Merit-Based Incentive Payment System

Modified By
Bipartisan Budget Act of 2018

Interpreted By
Annual Rulemaking 2019

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About the Bipartisan Budget Act

- Allowing 3 additional transition years
- More flexibility on Cost
  - min 10
  - max 30
- Performance threshold flexibility

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2019 Quality Payment Program (QPP) **Rulemaking Timeline**

- Part of the annual "…**Revisions to Payment Policies under the Physician Fee Schedule…**"
- July 12, 2018: Proposed rule available in Federal Register
- September 10, 2018: 60-day comment period closed
- November 1, 2018: Final Rule published
- December 31, 2018 Comments on the final rule accepted until

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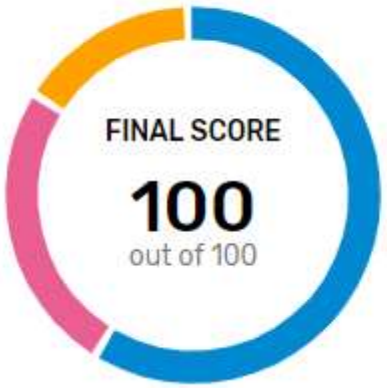
Reflections on 2017

- 91% of eligible clinicians participated
- Mean Final Score was 74.01
- Median Final Score was 88.97
- 1.88% maximum incentive



Performance Category Scores	
Quality	60 of 60
Advancing Care Information	25 of 25
Improvement Activities	15 of 15

With thx to CMS

Payment Adjustment	0.29%
Exceptional Performance Adjustment	1.59%
Total MIPS Adjustment(s)	**+1.88%**

Payment Adjustment Date
January 1, 2019

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Estimates for 2019 Performance Year

- 798,000 clinicians will be MIPS eligible clinicians

  ± $390m + $500m Adjustments delivered in 2021

- 165,000 and 220,000 clinicians will become Qualifying APM Participants

  $600-$800m Lump sum incentive paid in 2020

- Mean final score ~ 69.53
- Median final score ~ 78.72

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High Points of the Rule

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What is at Stake (Theoretical)

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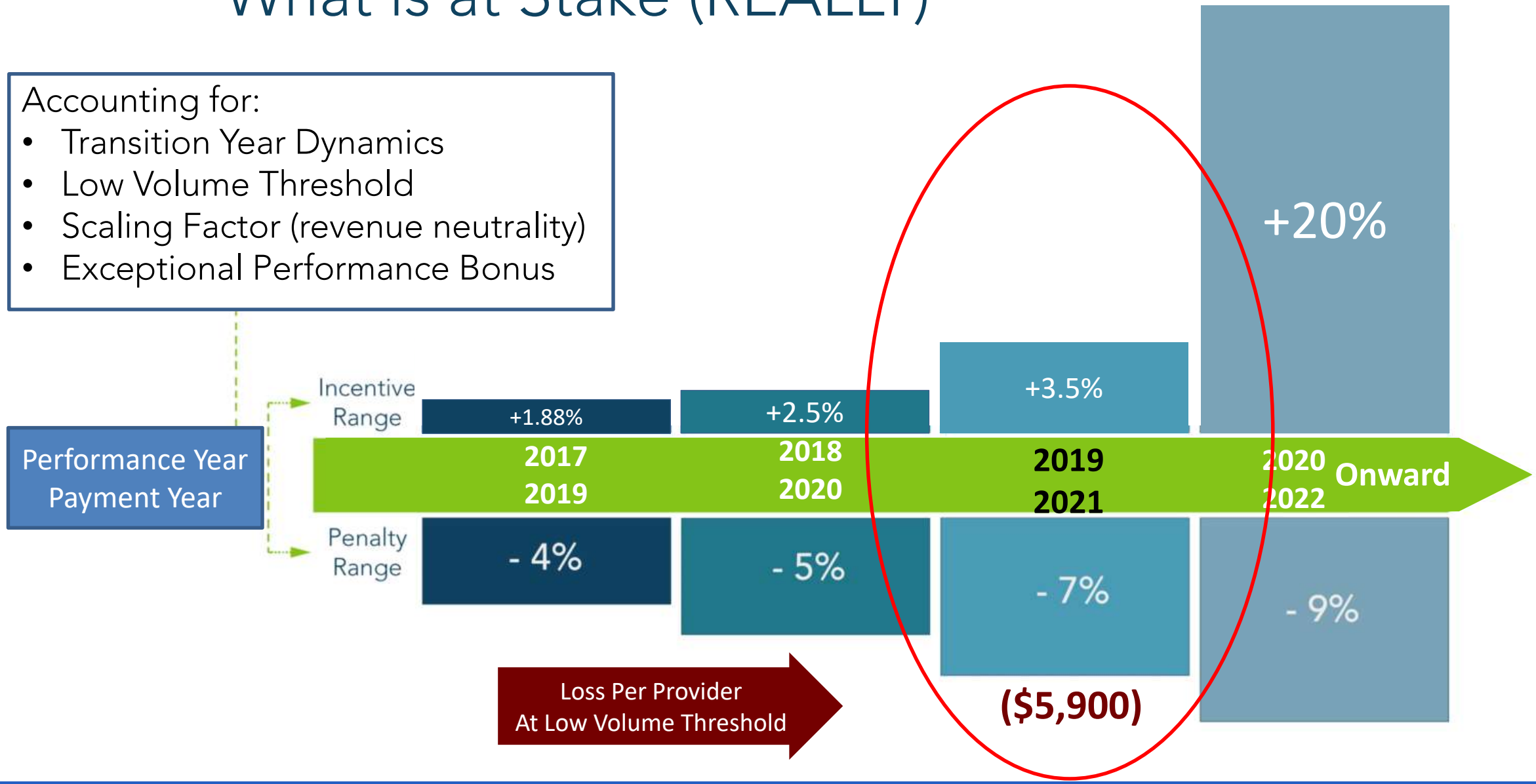
What is at Stake (REALLY)

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



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Performance Period and Weighting

Category	Performance Period	Weight 2019
Quality	Full Year	45%
Cost	Full Year	15%
Promoting Interoperability	90 – 365 days	25%
Improvement Activities	90 – 365 days	15%

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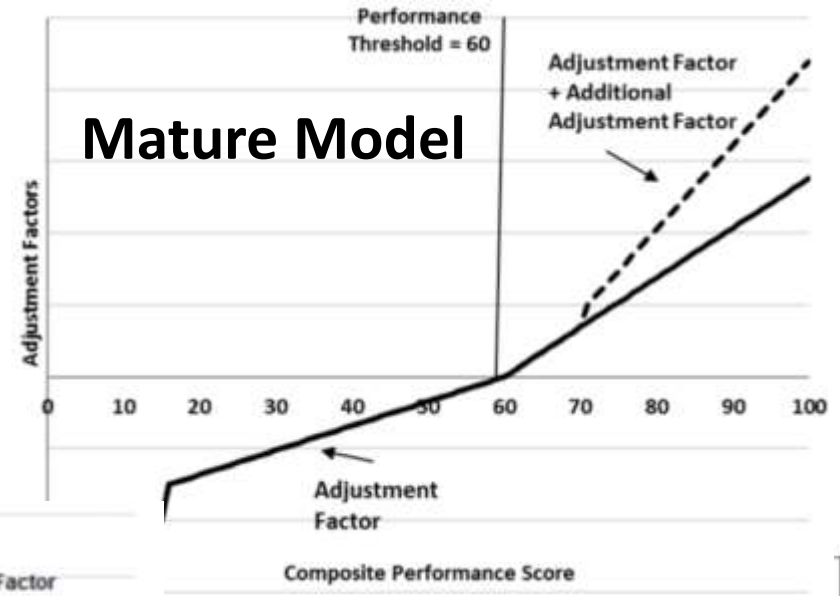
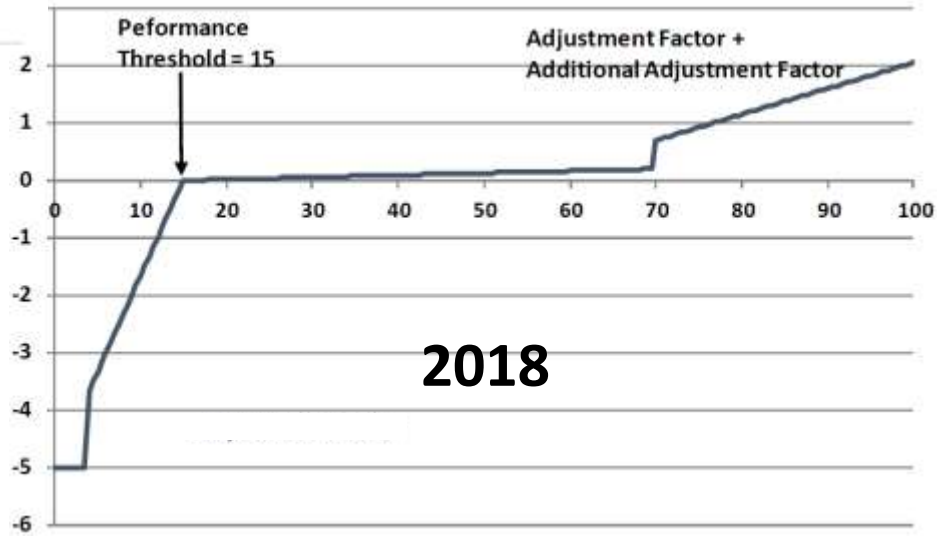
Historically & Graphically





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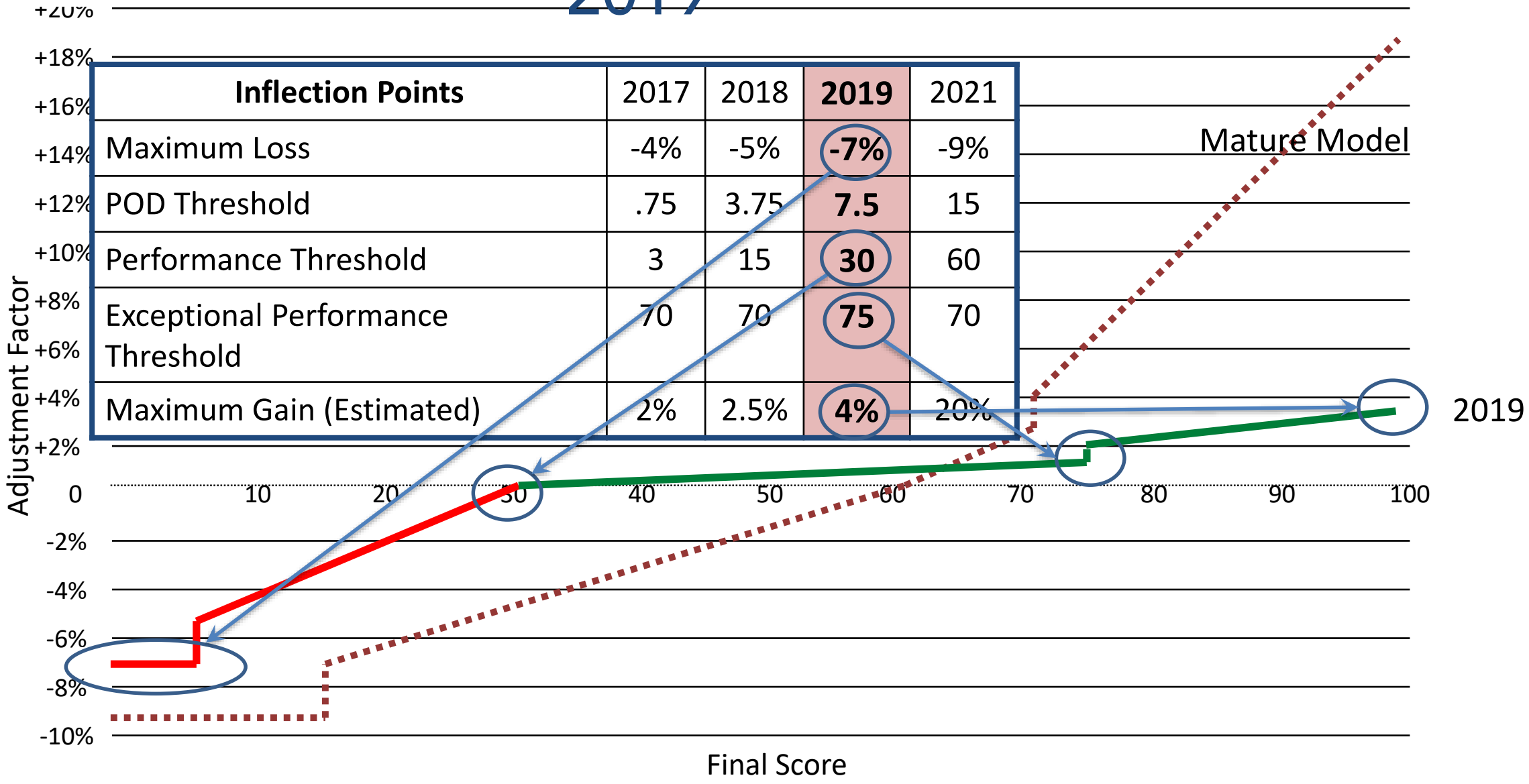
Relationship of Final Score to Adjustment - 2019

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	**75**	70
Maximum Gain (Estimated)	2%	2.5%	**4%**	20%



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Eligible Clinicians

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
- Physical Therapist
- Occupational Therapist
- Speech-Language Pathologist
- Audiologist
- Registered Dietician or Nutrition Professional

Still Ineligible

- Certified Nurse Midwife
- Clinical Social Worker

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Calculations including Incentive and Penalty Based Only on

Medicare Part B Professional Services

Drugs and Supplies billed thru Part B no longer included

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Low Volume Exclusion Changed

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

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Opt-in

- Individual 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

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Support Multiple Collection Types

- Single measure submitted multiple times
  - Latest of single collection type
  - Greatest number of measure achievement points for multiple collection types
- Groups and Virtual Groups included
- Web Interface stands alone except for
  - Administrative claims
  - Survey measure

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New Terminology
Submissions for Individuals

Performance Category/Submission Combinations Accepted	Submission Type	Submitter Type	Collection Type
Quality	Direct Log in and upload Medicare Part B claims (small practices)[1]	Individual or Third Party Intermediary[2] Individual	eCQMs MIPS CQMs QCDR measures Medicare Part B claims measures (small practices)
Cost	No data submission required[2]	Individual	-
Promoting Interoperability	Direct Log in and upload Log in and attest	Individual or Third Party Intermediary	-
Improvement Activities	Direct Log in and upload Log in and attest	Individual or Third Party Intermediary	-

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New Terminology
Submissions for Groups

Performance Category/Submission Combinations Accepted	Submission Types	Submitter Type	Collection Type
Quality	Direct Log in and upload CMS Web Interface (groups of 25 or more eligible clinicians) Medicare Part B claims (small practices)[1]	Group or Third Party Intermediary	eCQMs MIPS CQMs QCDR measures CMS Web Interface measures Medicare Part B claims measures (small practices) CMS approved survey vendor measure Administrative claims measures
Cost	No data submission required[1,2]	Group	-
Promoting Interoperability	Direct Log in and upload Log in and attest	Group or Third Party Intermediary	-
Improvement Activities	Direct Log in and upload Log in and attest	Group or Third Party Intermediary	-

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Single "MIPS Determination Period"

- 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
- **Status is applicable if applicable in either period**

- For all determination of eligibility and special status:
  - Low-volume
  - Non-patient facing
  - Hospital based
  - Small practice
  - ASC-based

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Implement Facility Based Scoring

- Automatically apply Facility Cost/Quality VBP scores if beneficial
- Facility-Based Individuals
  - Where 75% of Charges come for POS 21,22,23 (≥1 service from 21 or 23)
  - Individual 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
- Must submit either IA or PI to qualify
- If the attributed hospital does not have a facility score for the year, NPI or TIN must participate in MIPS with another method

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TABLE 54: Performance Category Redistribution Policies Proposed for the 2021 MIPS Payment Year

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
- Scores for all four performance categories	45%	15%	15%	25%
Reweight One Performance Category				
-No Cost	60%	0%	15%	25%
-No Promoting Interoperability	70%	15%	15%	0%
-No Quality	0%	15%	40%	45%
-No Improvement Activities	60%	15%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability	85%	0%	15%	0%
-No Cost and no Quality	0%	0%	50%	50%
-No Cost and no Improvement Activities	75%	0%	0%	25%
-No Promoting Interoperability and no Quality	0%	15%	85%	0%
-No Promoting Interoperability and no Improvement Activities	85%	15%	0%	0%
-No Quality and no Improvement Activities	0%	15%	0%	85%

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New TINs and New NPIs in an existing TIN (reporting individually)
in the last 3 months of the performance year are invisible to CMS and have no reporting requirement and a presumed score at the performance threshold

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Report on 6 measures, with at least 1 outcome measure or high priority measure for at least 60% of Eligible Instances and a *full-year* of data

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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

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Topped Out Measure Policies

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 (SSMs)

New

- Extremely (98-100%) topped out Process measures can be proposed for removal in next rule-making year
- Topped out QCDR Measures subject to non-renewal in the following year.

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Changes to Measures for 2019

- 8 new MIPS quality measures
  - 4 patient reported outcome measures
  - 6 high priority measures
  - 2 within MM framework
- Retire 26 quality measures
- Opioid-related measures are now high-priority

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8 New Measures

- *Continuity of Pharmacotherapy for Opioid Use Disorder*
- *Average Change in Functional Status Following Lumbar Spine Fusion Surgery*
- *Average Change in Functional Status Following Total Knee Replacement Surgery*
- *Average Change in Functional Status Following Lumbar Discectomy Laminotomy Surgery*
- *Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture*
- *Average Change in Leg Pain Following Lumbar Spine Fusion Surgery*
- *Zoster (Shingles) Vaccination*
- *HIV Screening*

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Measures Removed in 2019

#	Measures Removed in 2019
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
122	Adult Kidney Disease: Blood Pressure Management
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
156	Oncology: Radiation Dose Limits to Normal Tissues
163	Diabetes: Foot Exam
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
224	Melanoma: Overutilization of Imaging Studies in Melanoma
251	Quantitative Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients
257	Statin Therapy at Discharge after Lower Extremity Bypass (LEB)
263	Preoperative Diagnosis of Breast Cancer

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Measures Removed in 2019

#	Measures Removed in 2019
276	Sleep Apnea: Assessment of Sleep Symptoms
278	Sleep Apnea: Positive Airway Pressure Therapy Prescribed
327	Pediatric Kidney Disease: Adequacy of Volume Management
334	Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)
359	Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging Description
363	Optimizing Patient Exposure to Ionizing Radiation: Search for Prior Computed Tomography (CT) Studies Through a Secure, Authorized, Media-Free, Shared Archive
367	Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use
369	Pregnant Women that had HBsAg Testing
373	Hypertension: Improvement in Blood Pressure
423	Perioperative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy
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)
447	Chlamydia Screening and Follow Up

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Meaningful Measures & Web Interface

- 5 Measures removed for 2019 (see table)
- High Priority Bonus points no longer awarded for Web Interface submissions

#	Measures Removed for 2019
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

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Benchmarks

- Benchmarks are specific to collection type (eCQMs; QCDR; MIPS CQMs; claims; Web Interface; Survey; Administrative Claims)
- QCDR measure for which data is abstracted through EHRs or manually (that is, paper records) will have to be approved as two separate measures. Each measure would only be compared to its own benchmark.

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TABLE 50: Quality Performance Category: Scoring Measures

Class 1b = 7 points for topped out measure

Measure type	Description	Scoring rules
Class 1	For the 2018 and 2019 MIPS performance period: Measures that can be scored based on performance. Measures that were submitted or calculated that met the following criteria: (1) Has a benchmark; (2) Has at least 20 cases; and (3) Meets the data completeness standard (generally 60 percent.)	For the 2018 and 2019 MIPS performance period: 3 to 10 points based on performance compared to the benchmark.
Class 2*	For the 2018 and 2019 MIPS performance period: Measures that were submitted and meet data completeness, but do not have both of the following: (1) a benchmark (2) at least 20 cases.	For the 2018 and 2019 MIPS performance period: 3 points * This Class 2 measure policy does not apply to CMS Web Interface measures and administrative claims based measures
Class 3**	For the 2018 and 2019 MIPS performance period: Measures that were submitted, but do not meet data completeness criteria, regardless of whether they have a benchmark or meet the case minimum.	For the 2018 and 2019 MIPS performance period: 1 point except for small practices, which would receive 3 measure achievement points. Beginning with the 2020 MIPS performance period: MIPS eligible clinicians other than small practices will receive zero measure achievement points. Small practices will continue to receive 3 points. **This Class 3 measure policy would not apply to CMS Web Interface measures and administrative claims based measures

Change in Clinical Guidelines

reduce the denominator by 10 points for each measure submitted that is impacted by significant clinical guideline changes (impact to patient safety)

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Coding updates

Measures significantly affected by routine October Code changes will be subject to a 9-month reporting window

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Total Cost Per Capita Cost (TPCC)
Medicare Spending per Beneficiary (MSPB)
8 new Episode Measure
- 5 procedures measures
- 3 inpatient medical condition measures

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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

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Procedural & 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

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3 Episode group types

- Procedural
- Acute Inpatient Medical Condition
- Chronic

- Specifications for each group includes
  - Trigger Event
  - Service Assignment Rules
  - Risk Adjustment
  - Episode sub-groups

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Security Risk Assessment
CEHRT 2015
5 Mandatory Performance Measures

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Interoperability Defined as

- health information technology
- that enables the secure exchange of electronic health information with
- and use of electronic health information from,
- other health information technology
- without special effort on the part of the user
- allows for complete access, exchange, and use of all electronically accessible health information
- for authorized use under applicable law
- Without information blocking

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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

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Removal bonus for activities that utilize CEHRT

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Improvement Activities

- 15% of Final Score
- Theme of changes to improvement activities
  - Trying to make descriptions and activities more inclusive of specialists
- Adding 6 activities, Removing 1, Modifying 5.
- Removal IA that earn bonus for PI use
  - "Not an effective way to emphasize CEHRT"

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Bonus Points

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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
  - 6 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

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The Rhetoric behind the Rules

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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

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Priorities

- Reduce clinician burden
- Retire topped out process measures
- Fund new quality measure development
- New episode-based cost measures
- 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”

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Small and Rural Practices

- Small Practice Bonus retained in the Quality Performance Category
- Free and customized resources available within local communities
- Direct support from Small, Underserved, and Rural Support Initiative
- allow small practices to continue using the Medicare Part B claims collection type
- may continue to choose to participate in MIPS as a virtual group

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Modernizing Medicine

- Expanding traditional “telehealth” visits to recognize technology-based services
- Support non-visit care using telecommunications technology
- Collapse E&M levels 2,3,4 into one payment with simplified documentation

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MyHealthEData Initiative

"… aims to empower patients by ensuring that they control their healthcare data and can decide how their data is going to be used, all while keeping that information safe and secure."

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Meaningful Measures Initiative

"In addition to having the right measures, we want to ensure that the collection of information is valuable to clinicians and worth the cost and resources of collecting the information."

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Patients over Paperwork Initiative

- Evaluate and streamline regulations to
  - reduce unnecessary burden
  - increase efficiencies
  - improve the beneficiary experience
  - empower consumers
  - to have the information they need
  - to be engaged and active decision-makers

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60-day comment period closes at 5PM on December 31, 2018

- Submission options
- Electronically through **http://www.regulations.gov**
- Regular mail
- Express or overnight mail
- Hand or courier

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Q&A

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Q&A

Julie asks:

Is the reporting period 90 days in 2019? Do we have to be utilizing CEHRT 2015 for the entire year or is that also just within the 90 day reporting period?

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Q&A

Tracy asks:

What is the minimum points to avoid penalty and the simplest way to meet the requirements?

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Q&A

Beth asks:

Are there any new measures for Pathology or Radiology?

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Q&A

Sharon asks:
How does a specialty practice manage to decrease cost?

https://minglehealth.com/resource/webinar-mips-cost-medicare-spending-per-beneficiary-mspb/

https://minglehealth.com/resource/2018-mips-cost-performance-category-webinar/

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Q&A

Denise asks:

If the individuals do not qualify for reporting why should they report as a group all under the same tax ID?

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Q&A

Tina asks:

Is it going to be confusing reporting quality measures through different submission methods?

Are providers being pushed into utilizing QCDRs?

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