



Mingle Health

2019 Final Rule and Changes to MIPS Getting Started with MIPS in 2019

Presented by Dr. Dan Mingle

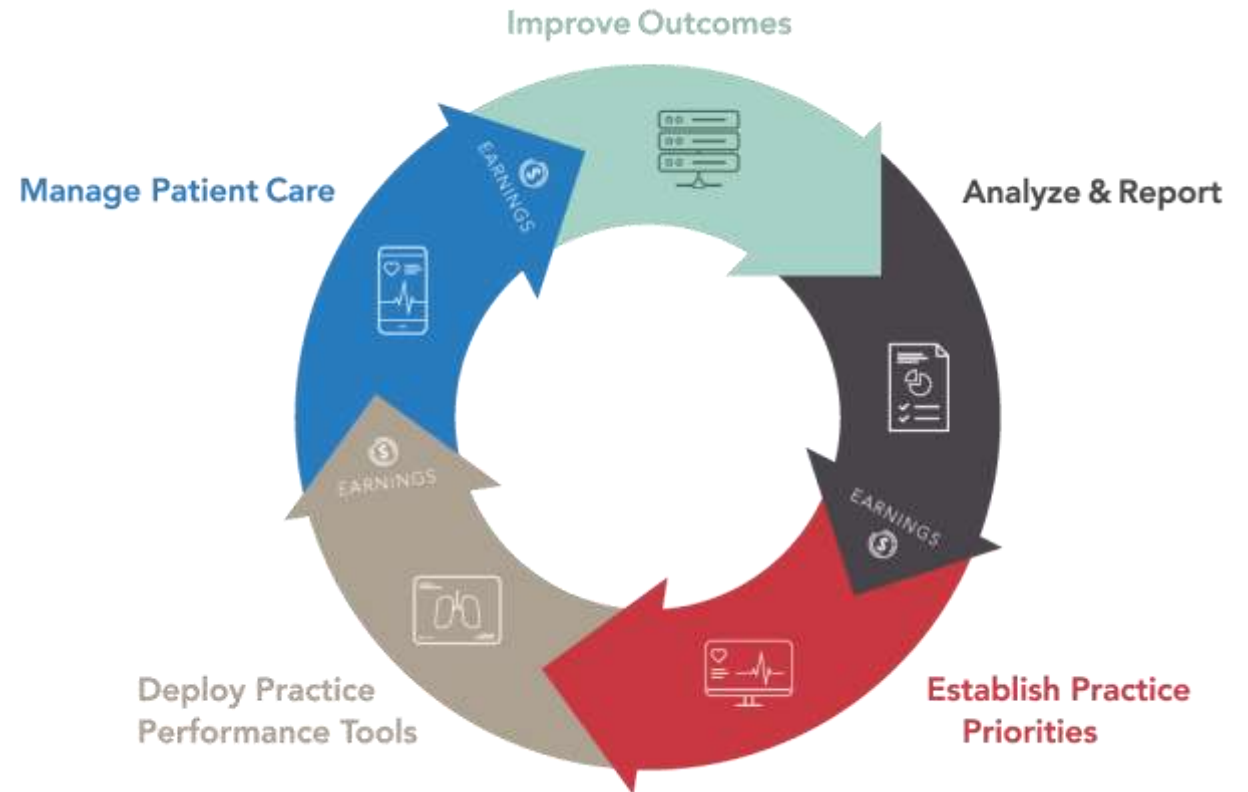
Mingle Health is your Partner for Value-Based Care

Improve What Matters

We guide you every step of the way in the transition to value-based care.

Mingle Health's software, services, and expertise will help you save time, improve outcomes, and increase earnings.

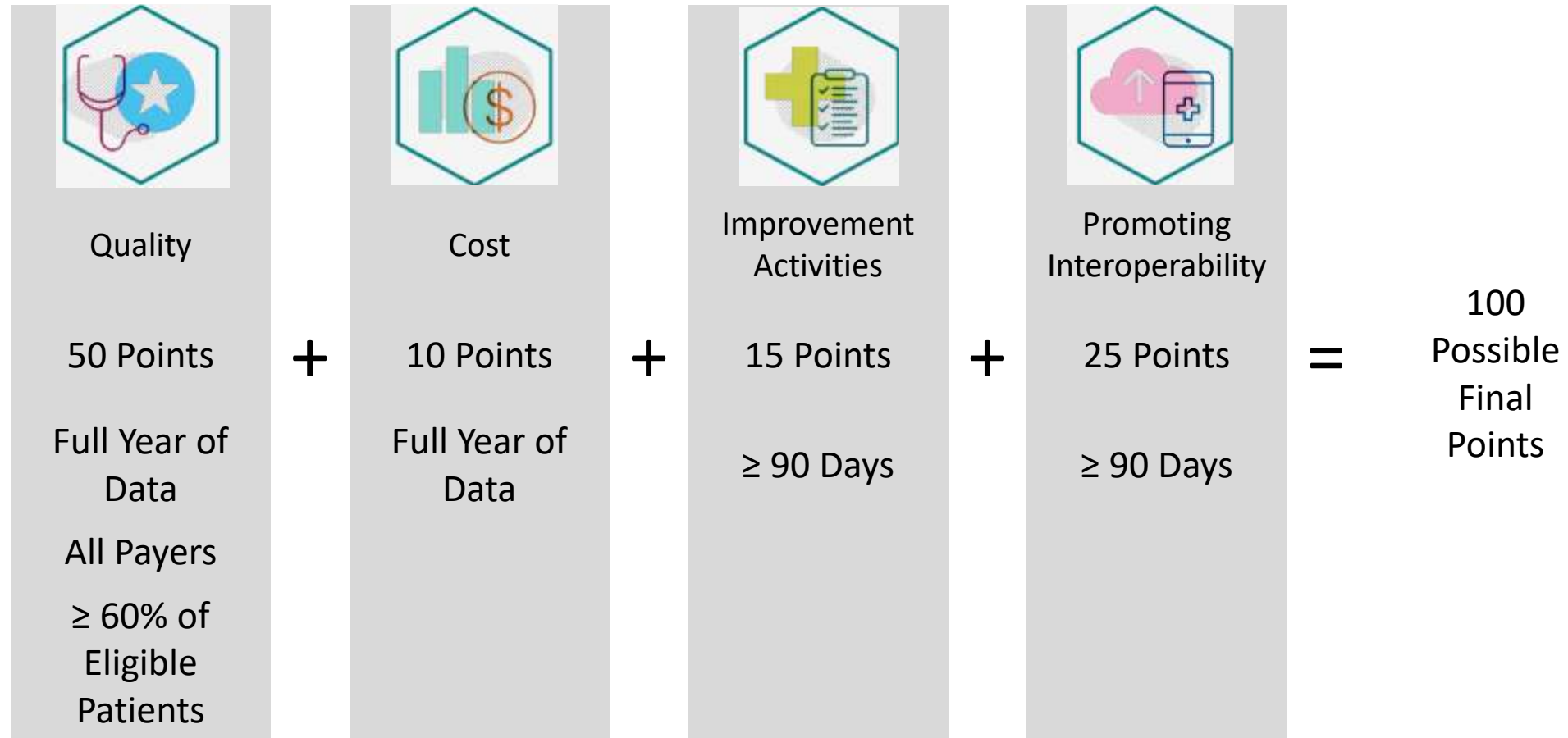
Successfully reported for 75,000 providers across all specialties since 2012.



Agenda

- Submitting for 2018
- How it works in 2019
- Miscellaneous Important Details
- What do I do now?

It's not too late to submit for 2018



How it Works - 2019

Starting in 2019

Incentive and Penalty Calculations Based Only on Medicare Part B Professional Services

Drugs and Supplies billed thru Part B no longer included

Annual Rhythm applied to 2019



Determination of

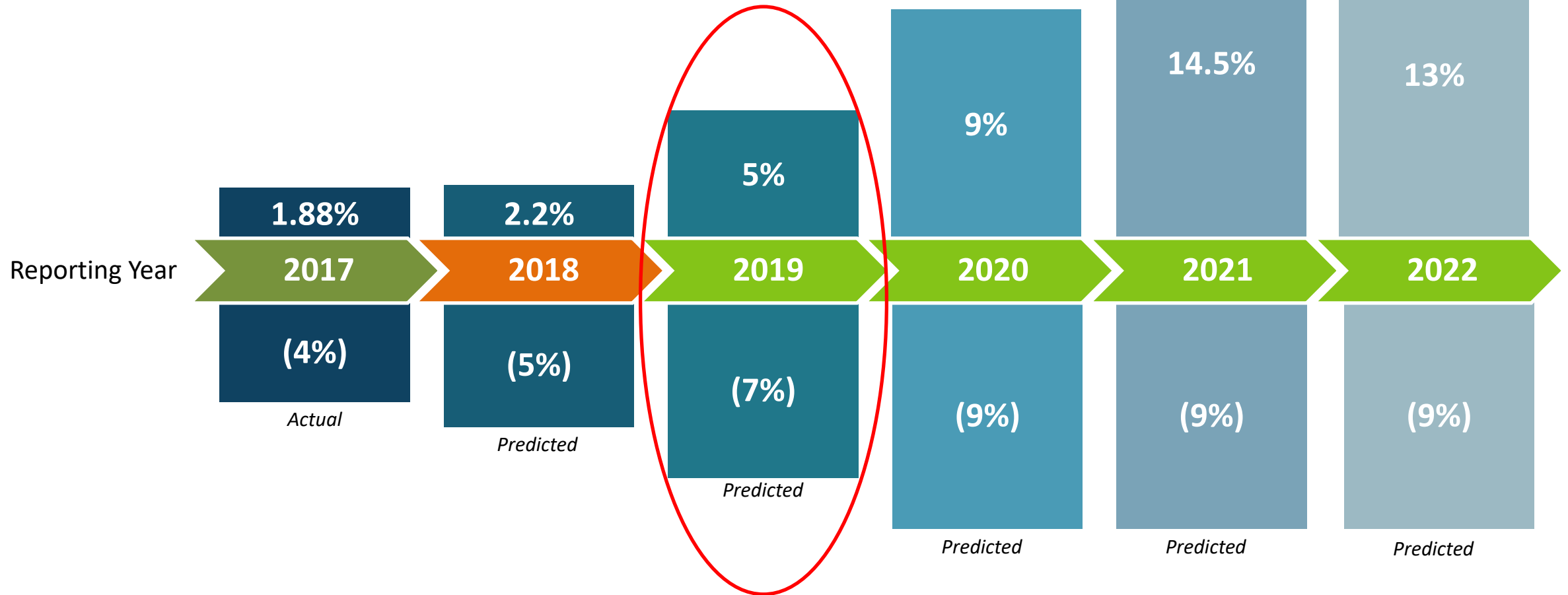
- Low Volume Status
- Small Practice Status
- Hospital Based
- Ambulatory Surgical Center-Based

Find your status at [QPP.CMS.GOV](https://www.cms.gov/qpp)

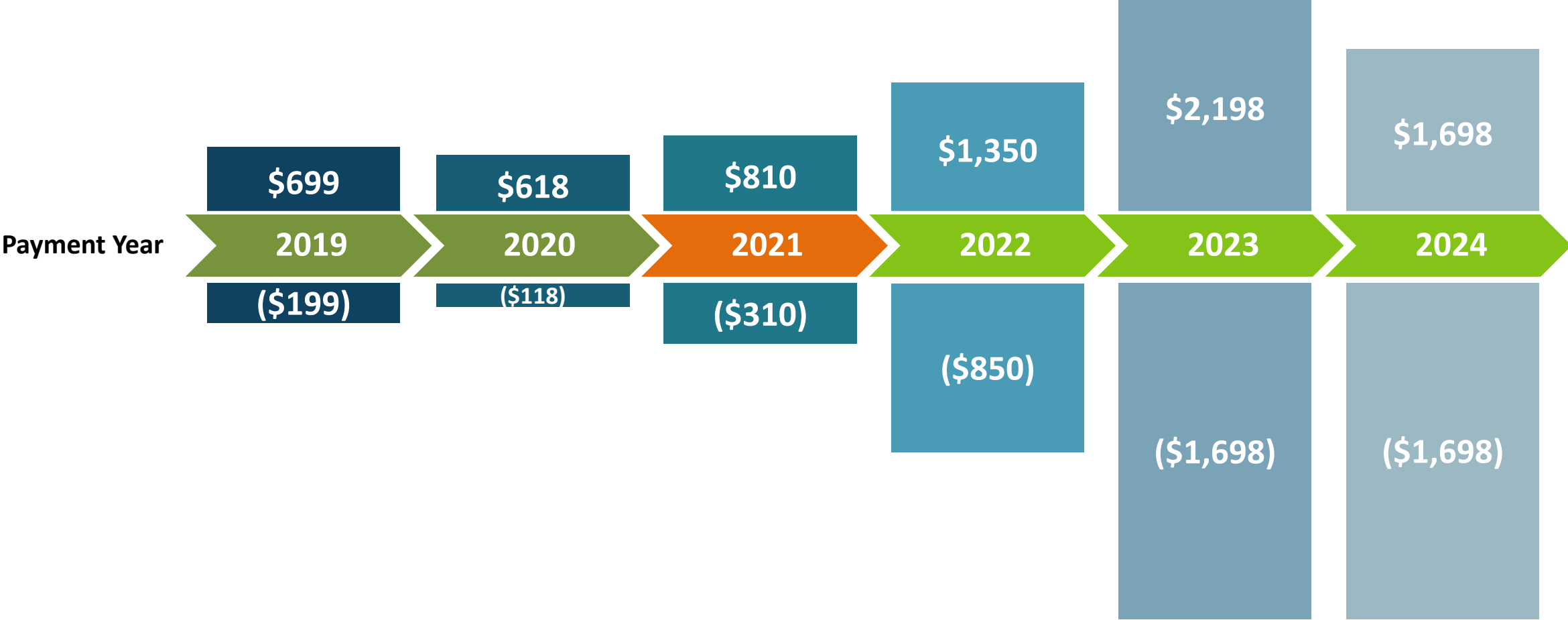
What is at Stake (Theoretical)



As Implemented



This is the MIPS Adjustment *RealFeel*



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

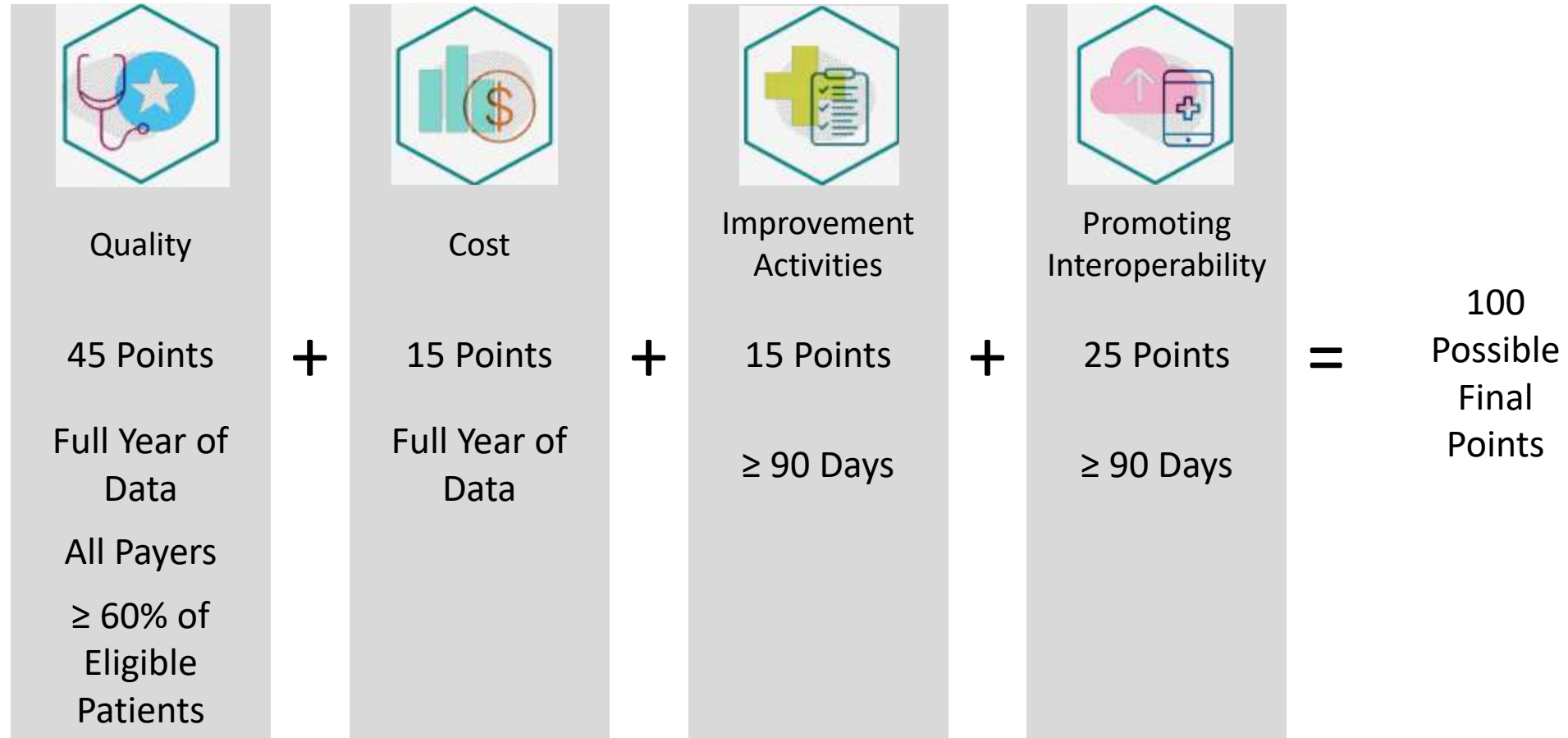
Low Volume Exclusion and Opting In

Included	Excluded	May Opt In
> \$90k Allowable Charges	≤ \$90k Allowable Charges	> \$90k Allowable Charges
AND > 200 Medicare Patients	OR ≤ 200 Medicare Patients	OR > 200 Medicare Patients
AND > 200 Charge Line Items	OR ≤ 200 Charge Line Items	OR > 200 Charge Line Items

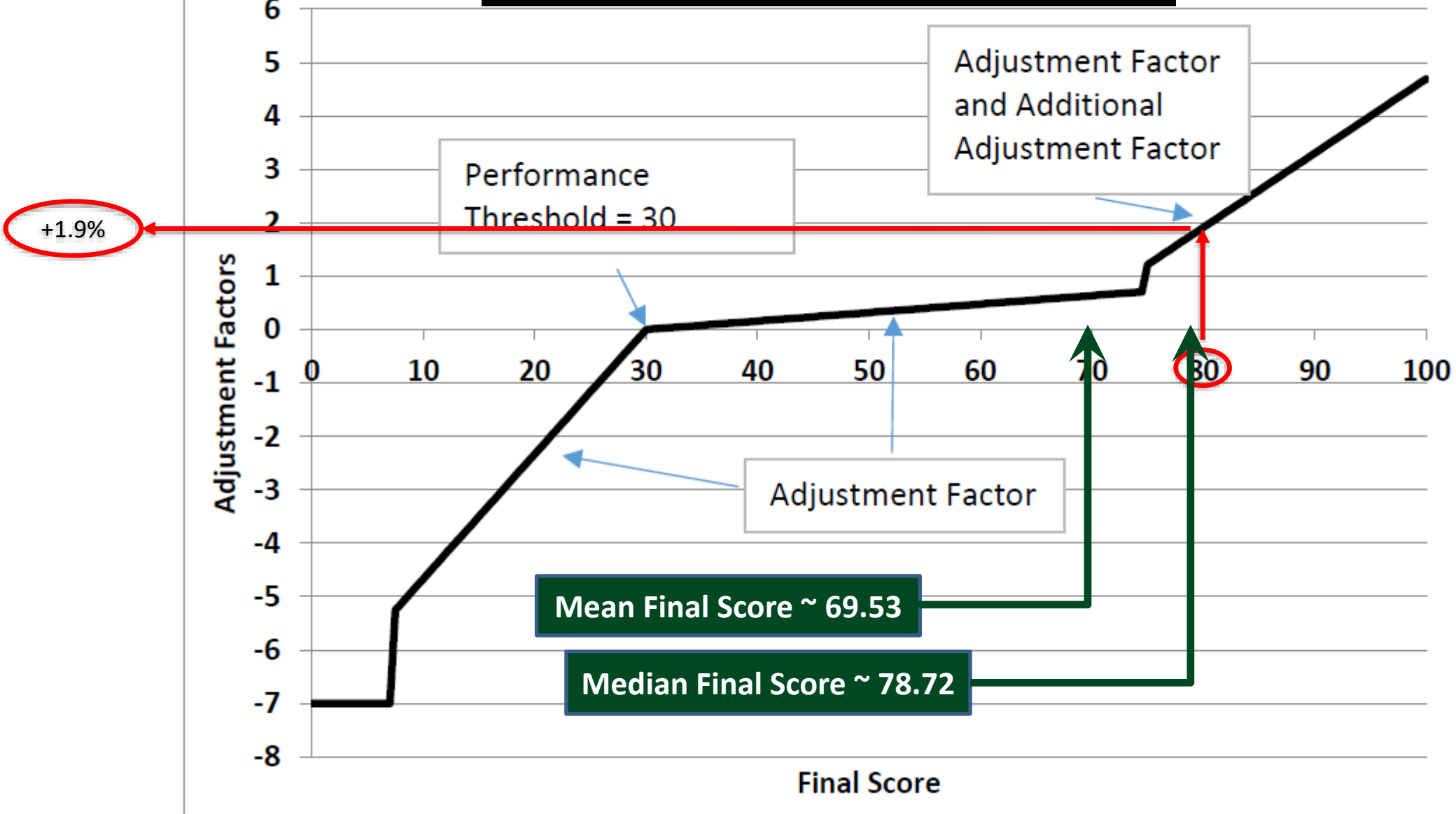
Opt-in

- Individual or group may opt in if:
 - MIPS Eligible
 - Qualifies for Low Volume Threshold by < 3 criteria
 - ≤ \$90,000 in Medicare Part B Charges
 - OR ≤ 200 Medicare Part B patients
 - OR ≤ 200 Medicare Part B services
 - Make irrevocable election in QPP Portal before the end of the year

4 Performance Categories



Your 2019 Reporting effects your 2021 Payments



Some Important Details

Exclusions from Categories

Type of Exclusion	How it's Applied	What it Effects	How it Effects
Extreme and Uncontrollable Circumstance	Automatic	Effects all Categories	Score set at Performance Threshold
Significant Hardship Exceptions	Application due by 12/31 of Performance Year	Effects any or all categories	Reweighting of scores to other categories
Excluded from "Meaningful Use"	Automatic	Effects Promoting Interoperability	Points redistributed to Quality
No applicable Cost Measures	Automatic	Effects Cost	Points redistributed to Quality

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%

Support Multiple Collection Types

- Mix and match measure submissions
 - Qualified Registry, QCDR, EHR, Claims
- When a single measure is 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

Facility Based Scoring

- Must make a submission to qualify
- CMS Automatically applies Facility Cost/Quality VBP scores if beneficial
- The attributed hospital may not have a facility score for the year
- 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 $\geq 75\%$ of MIPS Eligible Clinicians individually qualify as Facility-Based
 - Group attributed to hospital with plurality of their individual clinicians

Medicare Part B Claims Measures

- May only be used by small practices (≤ 15 providers)
- Beware: Claims is the least reliable collection type with a 60% historical failure rate.

Bonus Points

- Care of Complex Patients added to Final Score
 - CMS calculates from HCC codes and dual eligible rate
- End to End Electronic Reporting
 - one point for each measure
- Small Practice bonus if data small practice submits ≥ 1 quality measure
 - 6 points added to Quality Performance Category
- High Priority measures

Bonuses

- Small Practice Bonus applied to Quality Score

What do I do now?

Quality

2017

60%

2018

50%

2019

45%

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

Select your measures for 2019

- Start with what you submitted for 2018
- Choose 3-12 extra measures to work on
- Prepare for
 - Losing measures
 - Malperforming measures
 - Topped out measures
- A high performance level is not always best
 - Keep published benchmarks in mind

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.

Class 1 Measures

- Meets Data completeness criteria
 - 60% reporting rate
 - All payers
 - Full year of data
- Has a benchmark
 - Prepublished or generated during submission evaluation
- Your sample contains ≥ 20 patients
- Worth 3-10 points

Class 1b Measures

- Meets all the criteria for a Class 1 measure
- But is Topped Out
- Worth 7 Points

Class 2 Measures

- Meets Data completeness criteria
 - 60% reporting rate
 - All payers
 - Full year of data
- But
 - Does not have a benchmark
 - Or
 - your sample < 20 eligible instances
- Worth 3 Points

Class 3 Measures

- Does not meet data completeness criteria
- Must have an accurate denominator
- Worth 1 point
 - 3 points for small practices (≤ 15 providers)

Consider CAHPS

- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Counts for 1 measure
- Use a qualified survey vendor
- Additional Costs apply
- Must register your intention to use CAHPS
 - between April 1 and June 30, 2019
 - At CPP.CMS.GOV

Consider Web Interface

- Must be ≥ 25 providers to use
- There are 10 Web Interface Measures
- You must submit on 248 attributed Medicare Patients
- Must register your intention to use the Web Interface
 - between April 1 and June 30, 2019
 - At CPP.CMS.GOV

Web Interface Submissions

- Limited to practices of 25 or more providers
- 10 Required Measures
- For 248 attributed patients
- High Priority Bonus points no longer awarded for Web Interface submissions

#	Web Interface Measures for 2019
CARE-2	Falls: Screening for Future Fall Risk
DM-2	Diabetes: Hba1c Poor Control (>9%)
HTN-2	Controlling High Blood Pressure
MH-1	Depression Remission at Twelve Months
PREV-10	Tobacco Use: Screening and Cessation Intervention
PREV-12	Screening for Depression and Follow-Up Plan
PREV-13	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
PREV-5	Breast Cancer Screening
PREV-6	Colorectal Cancer Screening
PREV-7	Influenza Immunization

Cost

2018



2019



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

Medicare Calculates Cost from Claims no submission necessary

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 $\geq 30\%$ of E&M claim lines

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

Simple Rules to Contain Costs

- Availability and Accessibility
 - Efficient handoffs
 - Replace costly visits with telecare
 - Care Management – Proactive outreach
 - Avoid self-referral to ER or Specialty Care
- Avoid duplicative or excessive testing
- Avoid complications and returns to the hospital or ER
- Informed, prepared patients
- Skilled Care
 - The right facility
 - Not everyone needs it

Promoting Interoperability



25%

Security Risk Assessment
CEHRT 2015
5 Mandatory Performance Measures

Your EHR must have 2015 level certification

You must have a Security Risk Assessment

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

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	10 points
	<i>Bonus:</i> Query of Prescription Drug Monitoring Program (PDMP)	5 points bonus
	<i>Bonus:</i> 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	<u>Choose two of the following:</u> Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10 points

Improvement Activities (IA)



Improvement Activities

- Choose one or more activities for 2019
- There is still an advantage to group submissions
- Watch the rules, some activities have special limitations
- Keep a log of activities
 - Medicare suggests standards for documentation of activities

Thank you! – Q&A Time

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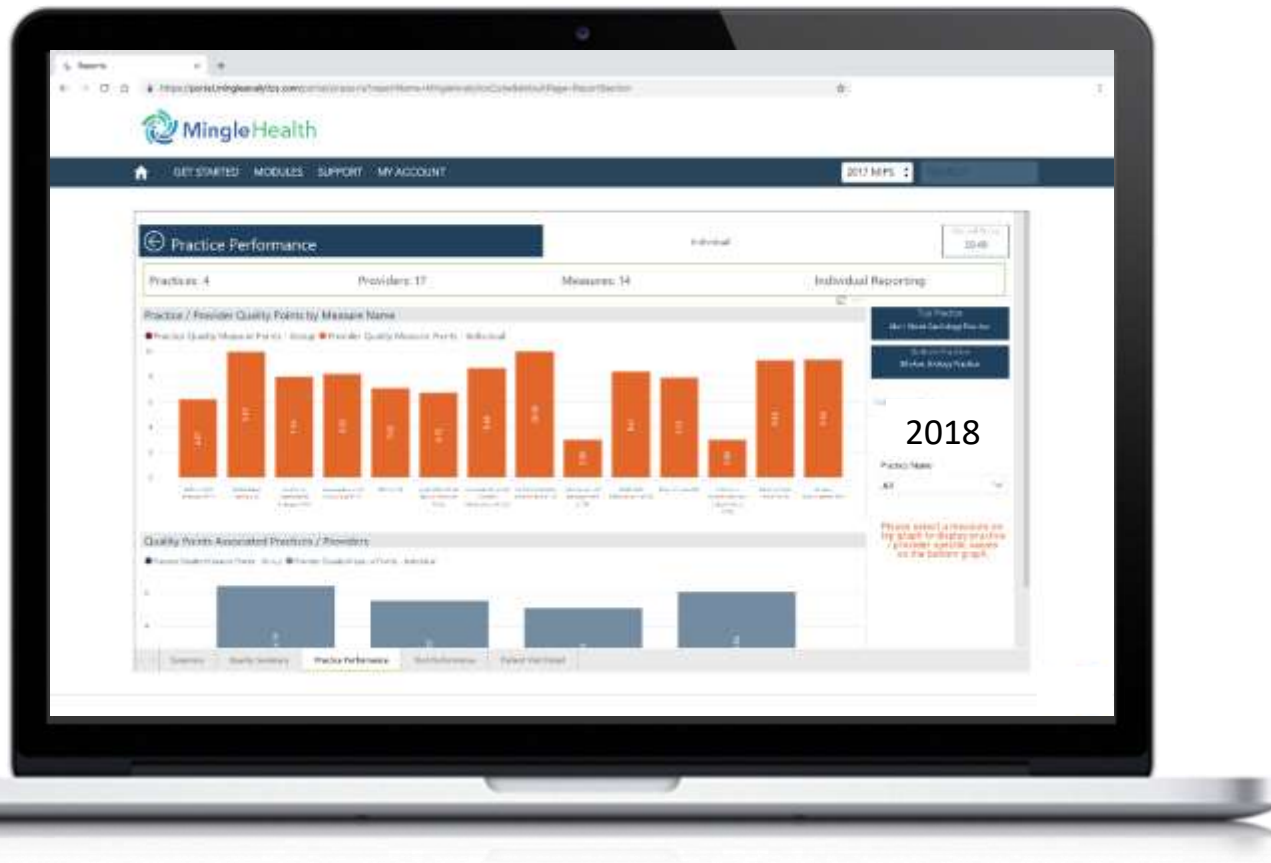
Have questions? Get in touch!

Email: hello@minglehealth.com

Call: 866-359-4458

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Daniel.Mingle@minglehealth.com



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