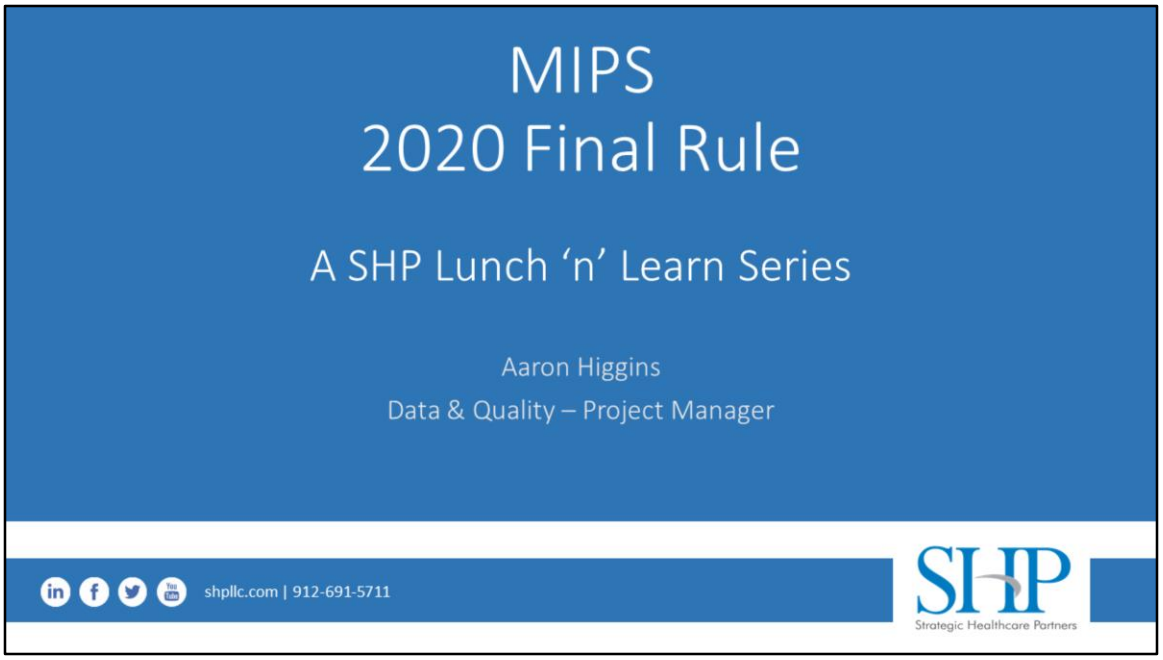

Welcome to the Final Rule webinar! This is our last MIPS Lunch 'n' Learn for 2019.

Speaker – Aaron Higgins

- Quality & Data Project Manager - SHP
- 10 years experience with Federal Quality programs, including Meaningful Use, PQRS, & MACRA/MIPS
- Joined SHP in the Spring 2019

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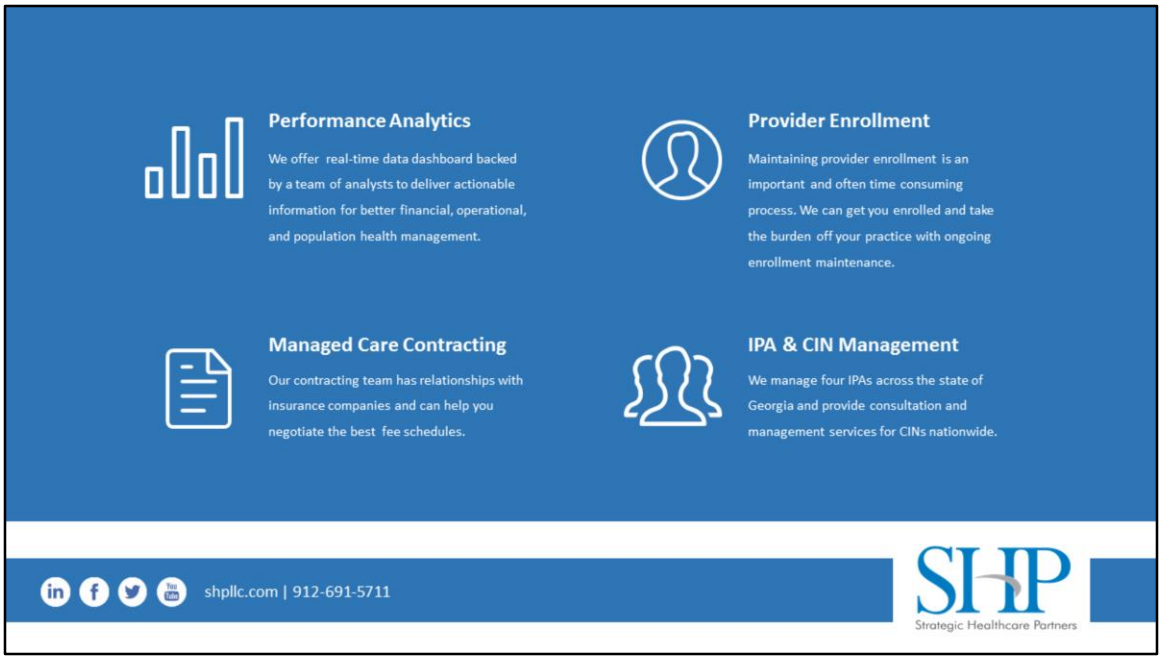
Now before we get going, let me introduce myself. I am Aaron Higgins, I've been with private practices since 2009 helping to create their quality programs, including Meaningful Use, PQRS and most recently MIPS. I joined SHP earlier this year.



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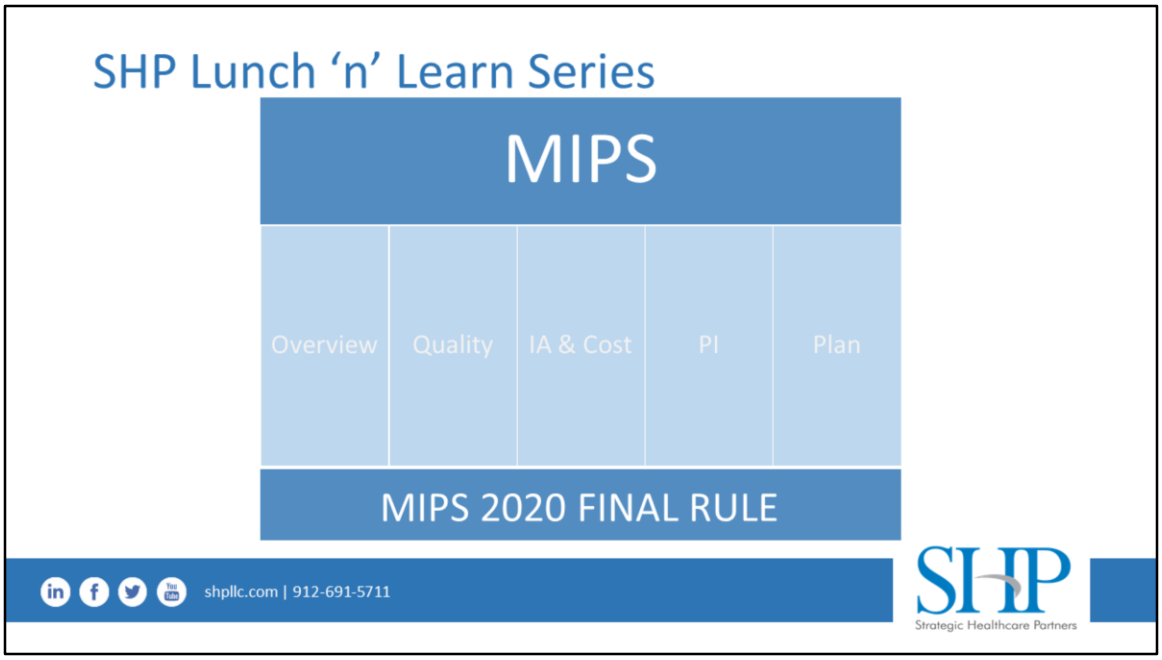
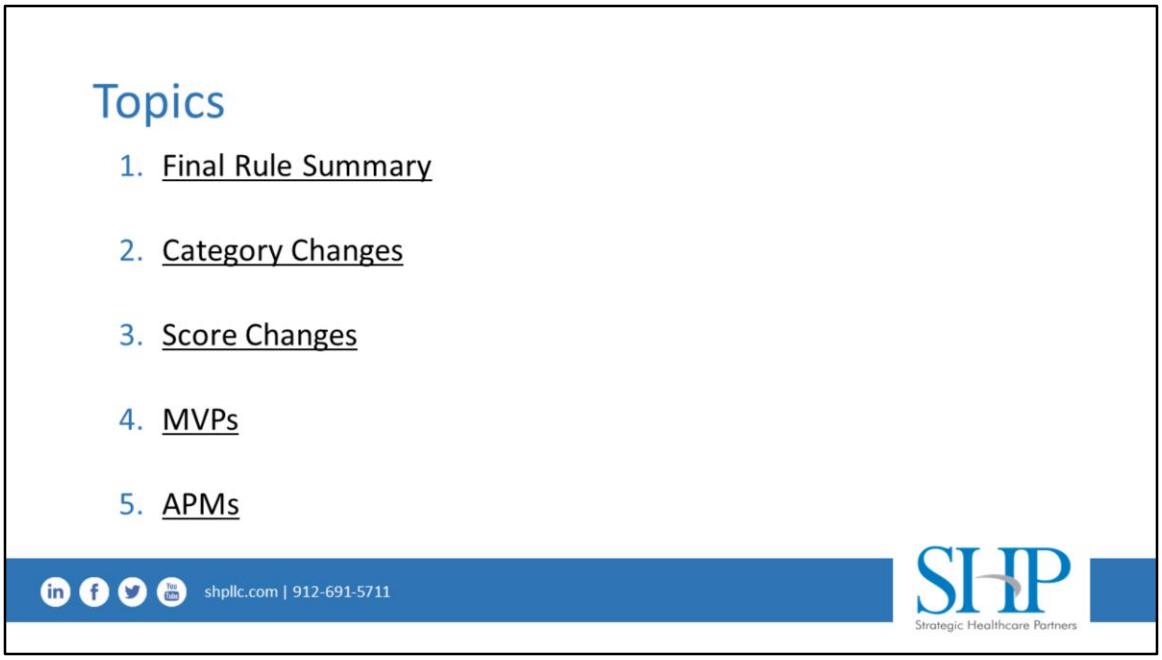
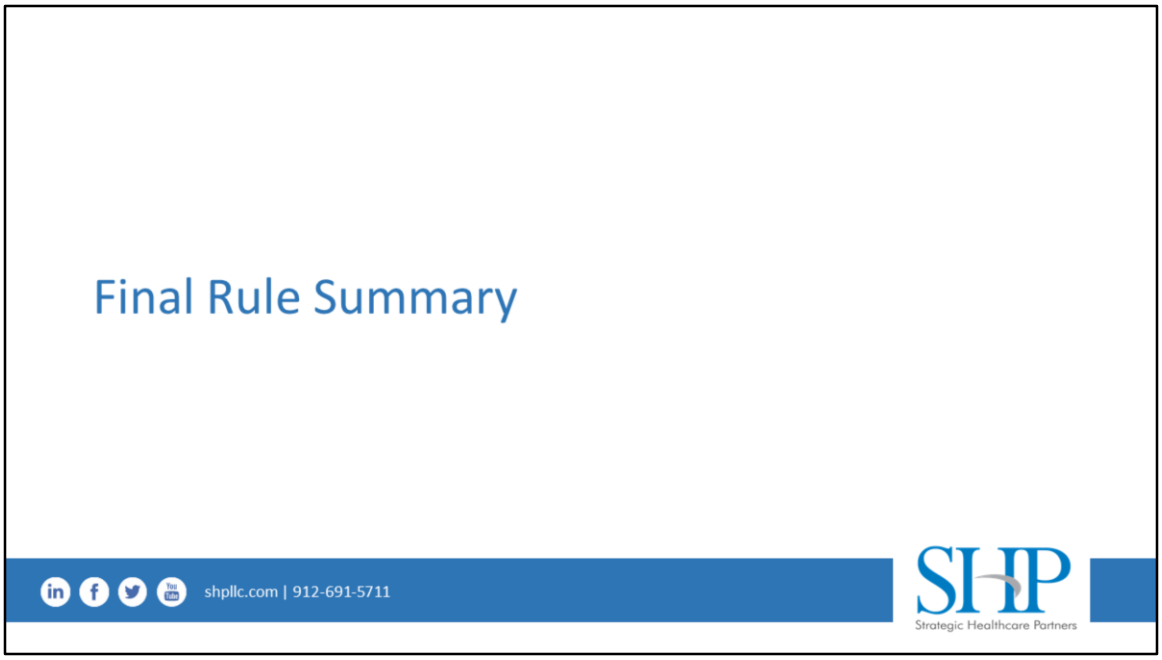


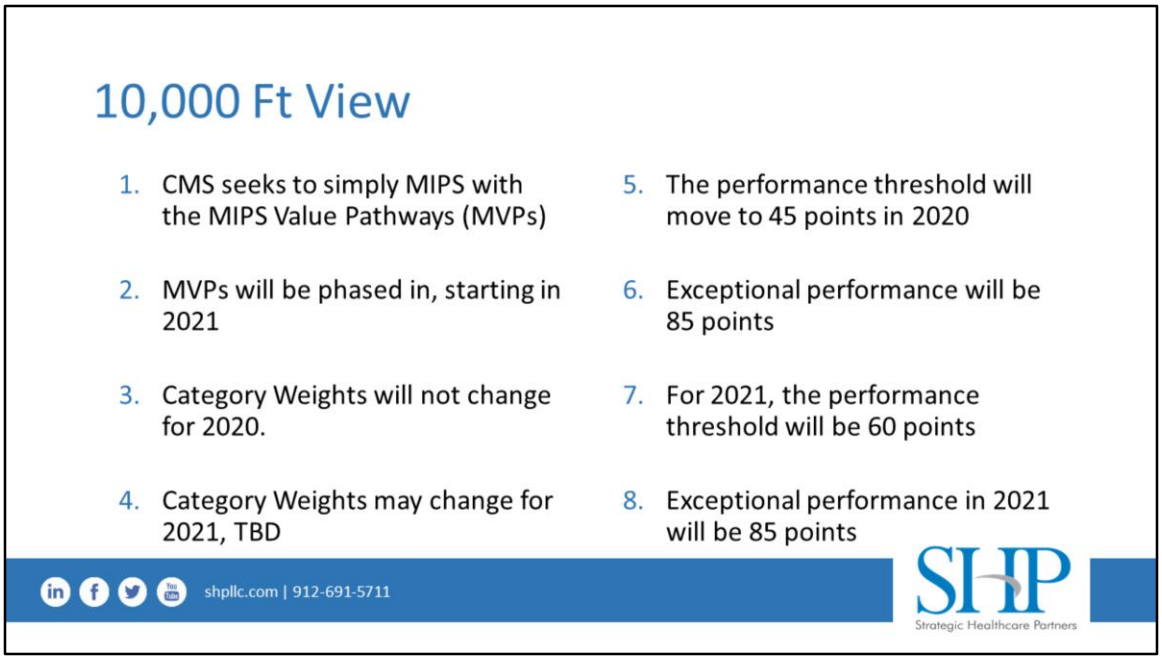
Over the past several weeks, we have gone through an overview of MIPS as well as deep dives into each of the categories. If you haven't yet seen these foundational series there is a link to review them in your invite email.



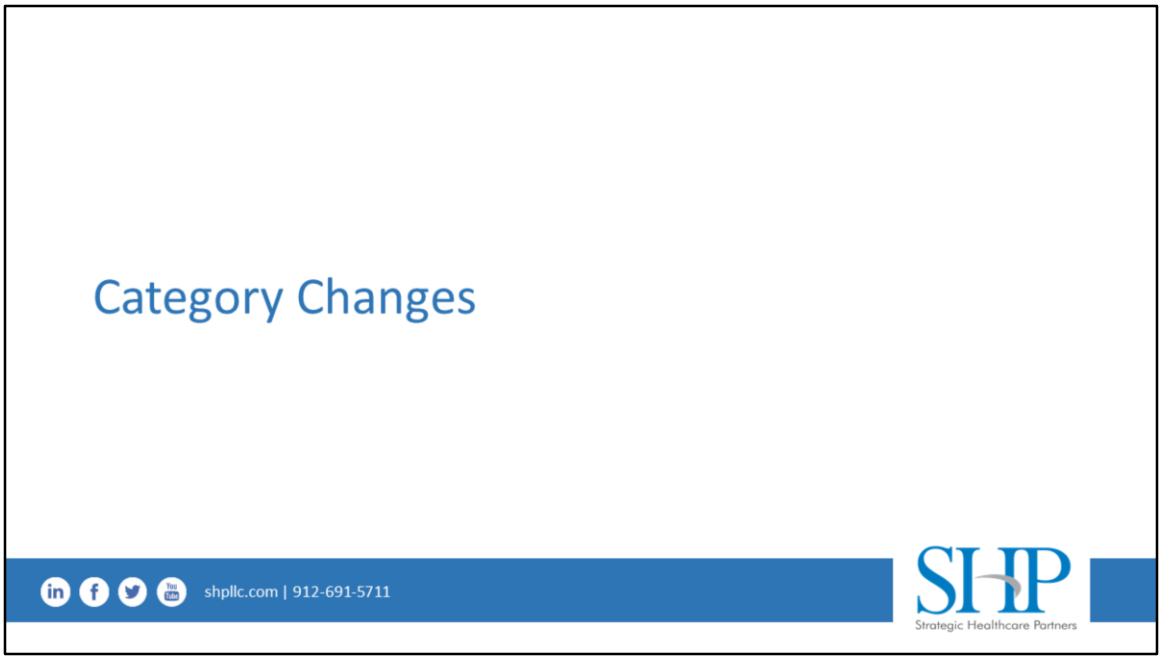
These are some of the topics that we are going to cover today. We have a lot to go through, so buckle up!



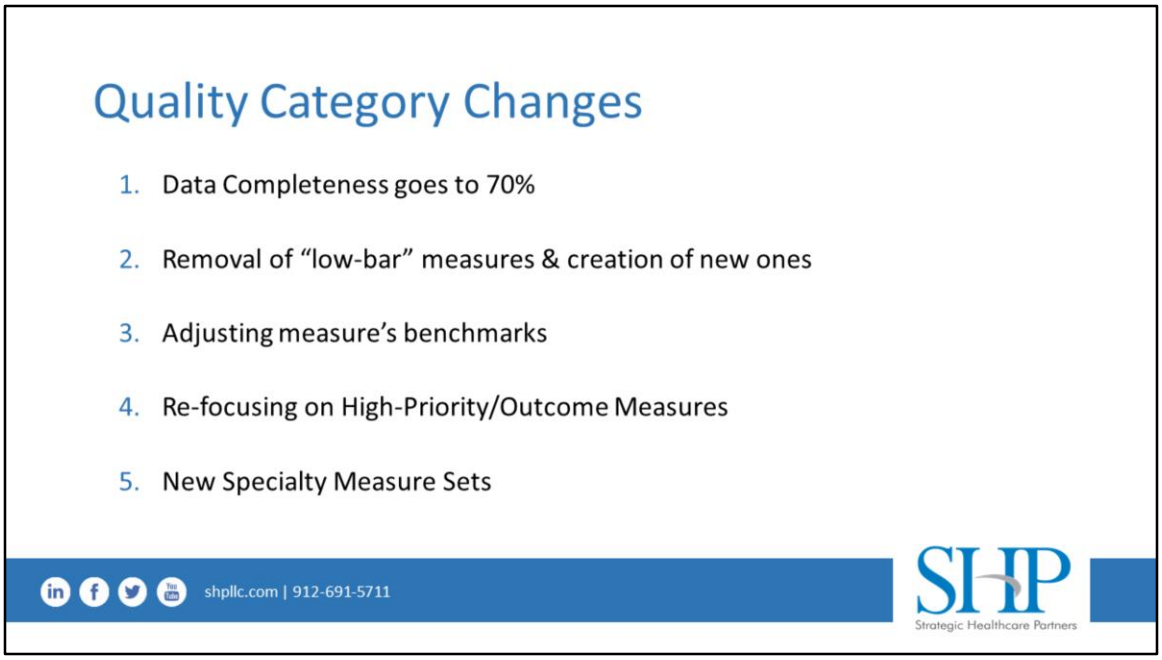
In late July, CMS released a 1704 page proposed rule change for MIPS. Then we entered into the comment period, where the public could give feedback on specific portions of the proposed rule. Taking all that feedback into account, CMS on November 1st, released a 2,475 page final rule. Fortunately, for you, you don't have to read that much to understand the changes.



1. One of the biggest takeaways from the final rule is that CMS is excited and eager to try out this new MVP participation method. We'll dive deeper into the MVPs here in a little bit, but…
2. CMS did say, repeatedly, there will be a phased approach to the MVP program. How exactly will happen, will explained throughout 2020.
3. In the Proposed Rule, they were going to increase the Cost category weight. However, based on feedback, the category weights are staying the same: Quality 45%, Cost 15%, PI 25%, and IA 15%.
4. That said, the categories are supposed to be at certain amounts come 2022, so there may be a jump in weights in 2021. That is to be decided in the 2021 Final Rule due next November.
5. In the proposed rule, the performance threshold was set at 45 to avoid a penalty, that is the case in the final rule as well.
6. However, the exceptional performance threshold was proposed to be set to 80, CMS raised the bar higher by setting it to 85.
7. In 2021, the performance threshold will follow the proposed one at 60 points
8. And the same goes for exceptional performance.

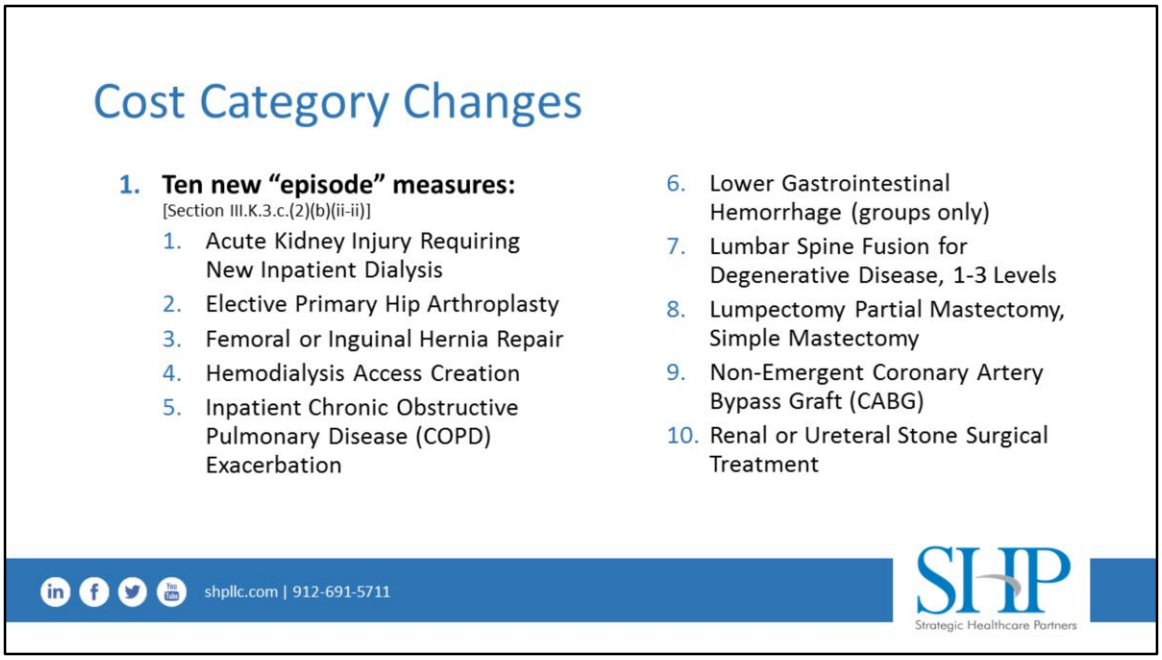


Let’s dive into each of the category’s changes.

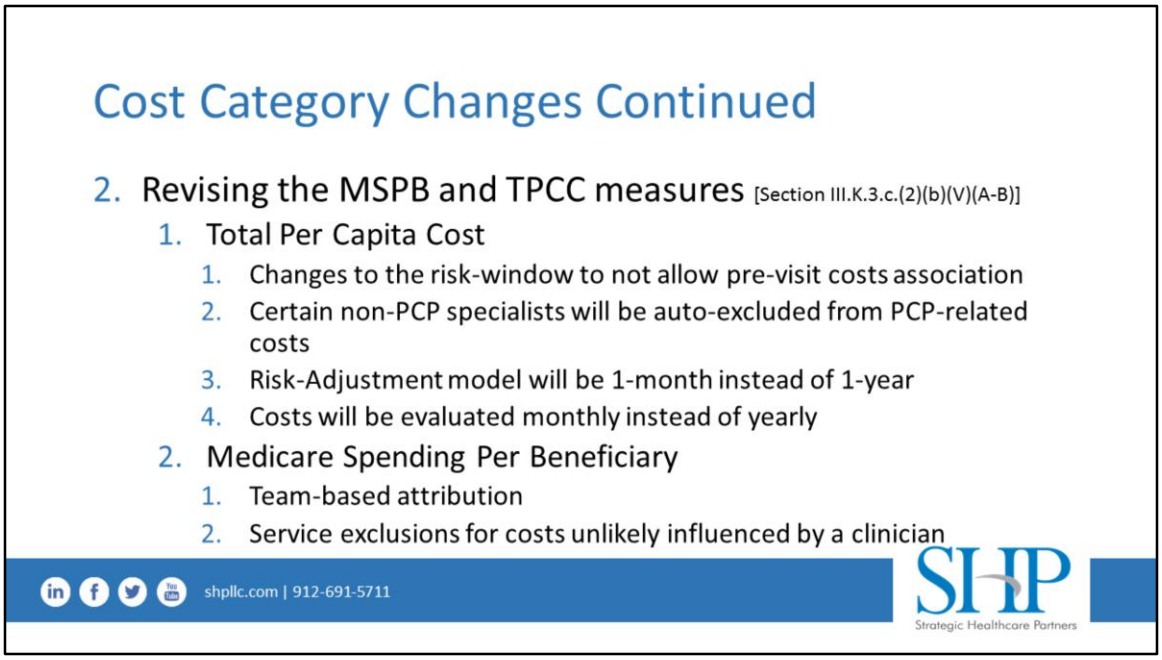


1. Previously, CMS required that 60% of all patients, regardless of payer, be in the represented data sample, but starting next year that will jump to 70% of patients. This shouldn't be a huge change for practices that use their EHR to report, but it may present a challenge for some QCDR or Registries out there.
2. CMS is aggressively going after what they feel are measures that are not living up to expectations or overlap with the purpose of other measures. CMS is also introducing several new measures to the lineup. A full list of measures are available in Appendix 1 of the 2475 page Final Rule.
3. Several dozen measures are also undergoing a facelift, with tweaks and changes coming to the benchmarks of some of the most popular measures.
4. To ensure practices are picking the High-Priority/Outcome Measures, CMS is clarifying that these measures do not have to have a benchmark to earn full points, unlike other measures that require a benchmark. They also kept the high-priority bonus points, up to 10%, intact through payment year 2022.
5. They are also introducing new specialty measure sets, these are recommended measures for specialists and are not required that a specialist use them. However, they are likely to be used/referenced with the MVP program. Something we'll cover here in a few minutes. The new sets are: Speech Language Pathology, Audiology, Clinical Social Work, Chiropractic Medicine, Pulmonology,

Nutrition/Dietician, and Endocrinology.



The dreaded Cost Category did not escape unchanged. 10 new specialty measures that will hopefully help (yes, help) you score better in this category. CMS' logic is that by diluting the measure pool, there will be less pressure to perform extremely well in the two original cost measures. CMS also said that they are continuing to develop with a third-party new Cost measures that will help ensure the category is a fair comparison between clinicians. The third-party is working right now with real clinicians and groups to beta-test these future measures. CMS will take that real-world feedback to create measures next year. The Cost category is a pillar of the MVPs idea, so having more Cost measures only makes sense.

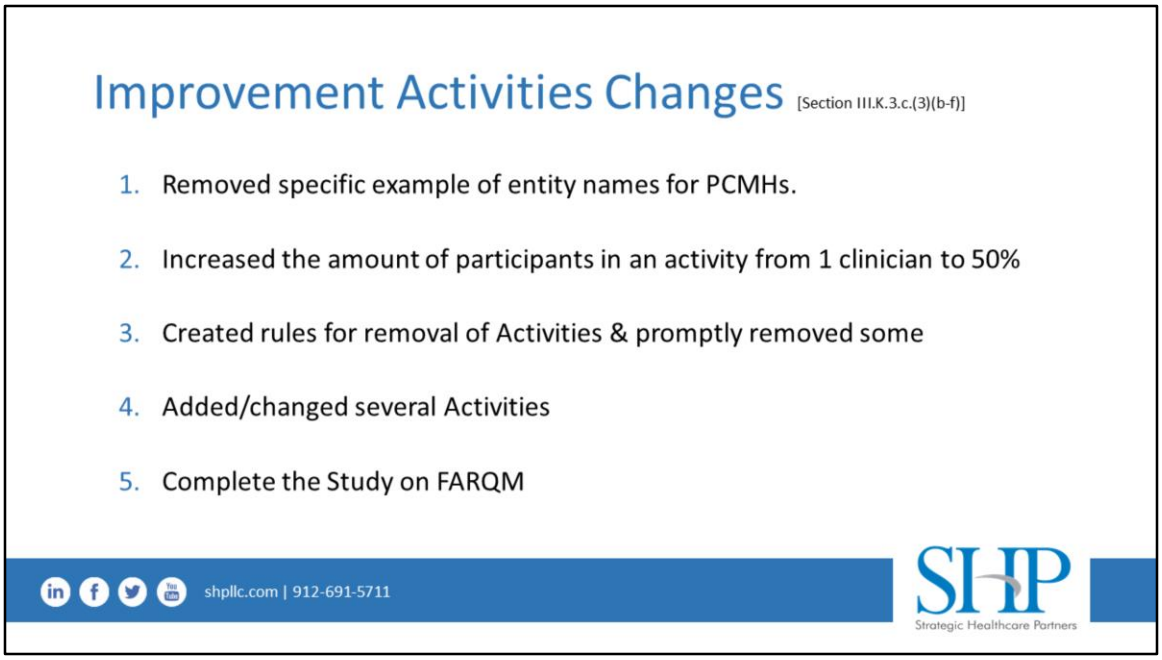


That said, those two core measures are also getting an update. Primarily around how patients are attributed to a provider….

For TPCC, costs could be associated to a provider before the clinician even saw the patient. This is being fixed to prevent earlier costs from being assigned to a clinician. So now only after the clinician first bills an E&M code service will the so-called risk window open.
Furthermore, clinician types that typically do not provide primary care services will automatically be excluded from attribution of non-specialty costs. This means a therapeutic radiologist will only have their costs associated with the care they provided, not the whole of the costs.
The Risk-Adjustment model is also being changed to be from a 1-year timeframe to 1-month, this will better reflect patients' trends.
Fourth, the costs will be evaluated on a monthly basis instead of an annual basis. This way when a patient dies, the actual cost will be reflected properly without skewing the whole year. This should help the overall performance of this measure.

For MSPB, CMS is breaking up the attribution by paying closer attention to who does what during an episode of care to account for the team-based nature of medicine.

Second, costs that are incurred during an episode of care that a clinician likely has no influence or say-so over, will removed from the clinician's score.



Improvement activities did not escape the attention of the Final Rule's editing pen.

1. CMS removed all references to specific accreditation entities for Patient Centered Medical Homes. There are more entities than they list in the past rules, and they did not want to exclude any current or future accreditation bodies.
2. They increased the amount of clinicians who participate in an activity from 1 in a group to 50% of the group. This does mean that you must document that not only did your clinicians do an activity, but that at least half of them participated in some way.
3. Before this Rule, CMS had no official way to remove/update Activities, this Rule created the process for doing so and then they promptly removed several of them. A full list of those will follow here in a few slides.
4. CMS introduced some changes to existing activities, providing better insight into how they work. They also added a handful of new ones.
5. Finally, as expected the alternative to Improvement Activities, the FARQM CMS Study, was officially ended.

We'll quickly move through these slides, if you want to know more about a specific IA change, feel free to send me an email.

New/Changed Improvement Activities Cont

- Changed - Implementation of formal quality improvement methods, practice changes, or other practice improvement processes
- Changed - Participation in a QCDR, that promotes use of patient engagement tools
- Changed - Use of QCDR data, for ongoing practice assessment and improvements in patient safety.
- Changed - Completion of Collaborative Care Management Training Program

Removed Activities

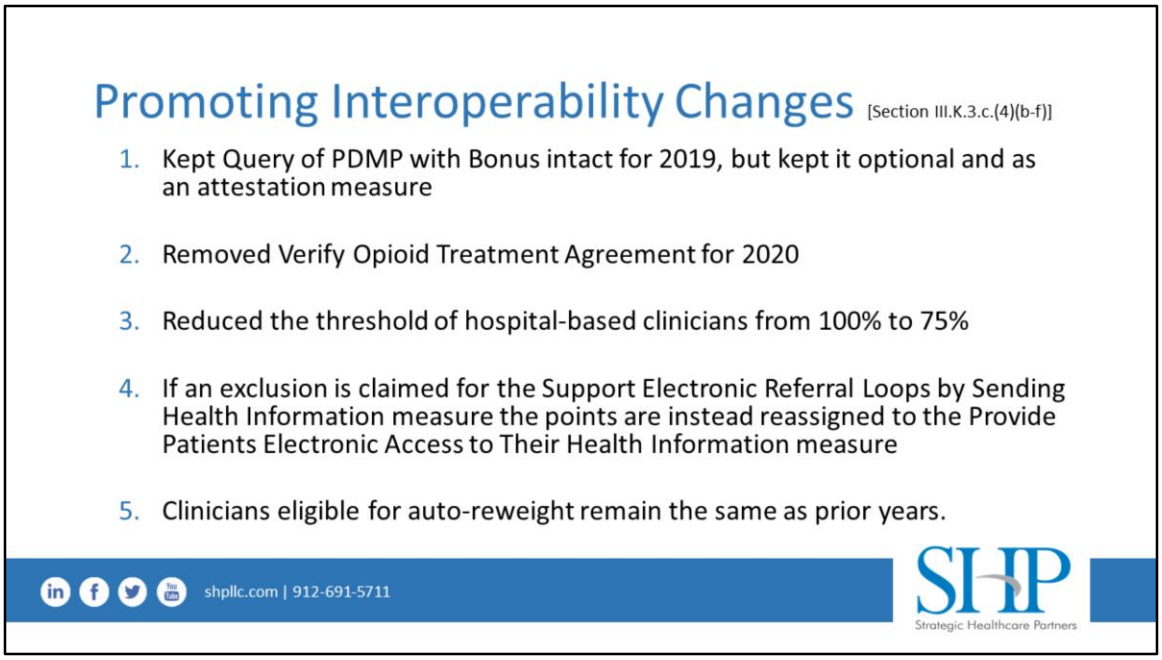
- Participation in Systematic Anticoagulation Program (reason: duplicative)
- Implementation of additional activity as a result of TA for improving care coordination (reason: duplicative)
- Participation in Quality Improvement Initiatives (reason: duplicative)
- Annual Registration in the Prescription Drug Monitoring Program (reason: duplicative)
- Initiate CDC Training on Antibiotic Stewardship (reason: duplicative)
- Unhealthy alcohol use (reason: duplicative)

Removed Activities Cont.

- Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan (reason: duplicative)
- Use of QCDR to support clinical decision making (reason: duplicative)
- Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement (reason: duplicative)
- Participation in a QCDR, that promotes implementation of patient self-action plans (reason: duplicative)
- Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination (reason: duplicative)

Removed Activities Cont.

- Leveraging a QCDR for use of standard questionnaires (reason: duplicative)
- Leveraging a QCDR to standardize processes for screening (reason: duplicative)
- Use of QCDR data for quality improvement such as comparative analysis reports across patient populations (reason: duplicative)
- Participation in CMS Transforming Clinical Practice Initiative (reason: the TCIP program ended on Sept 28, 2019)



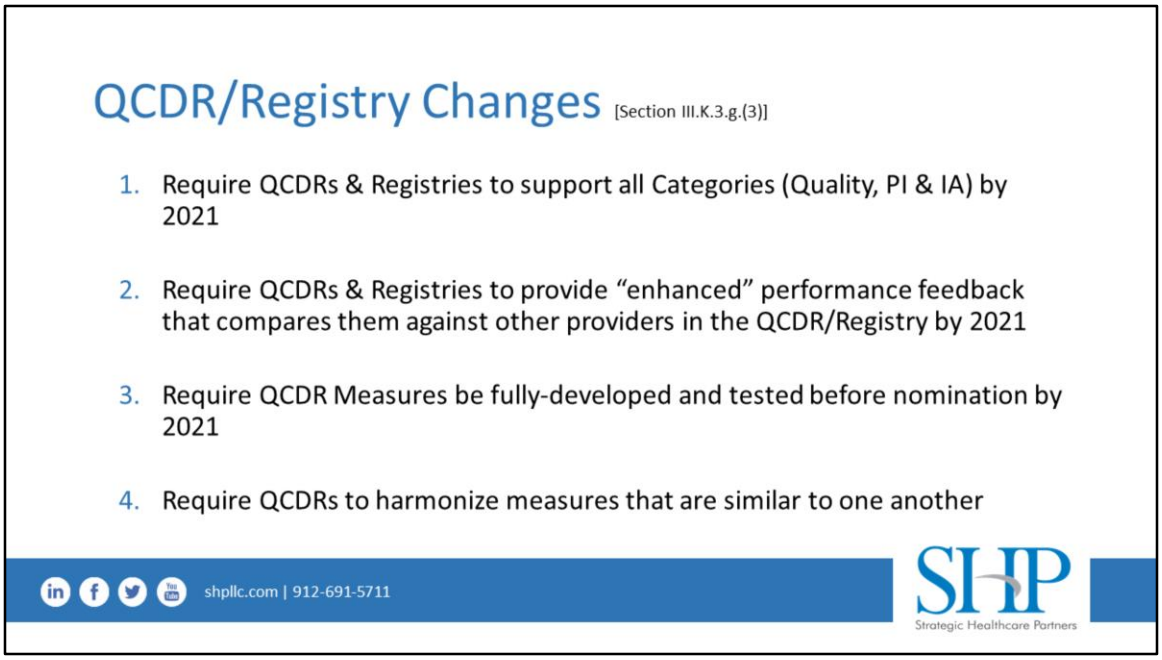
PI received the lightest touch, in my opinion.
The PDMP measure starting this year is now an attestation measure vs. a denominator/numerator. It is also still around for 2020 and remains optional, just as it is this year. It is still worth 5 bonus points.

As expected, the much disliked Verify Opioid Treatment Agreement was removed for 2020, both CMS and clinicians felt the measure does not achieve the goals it set out to accomplish. That said, it can be used for this year, so snag those extra 5 points if you can.

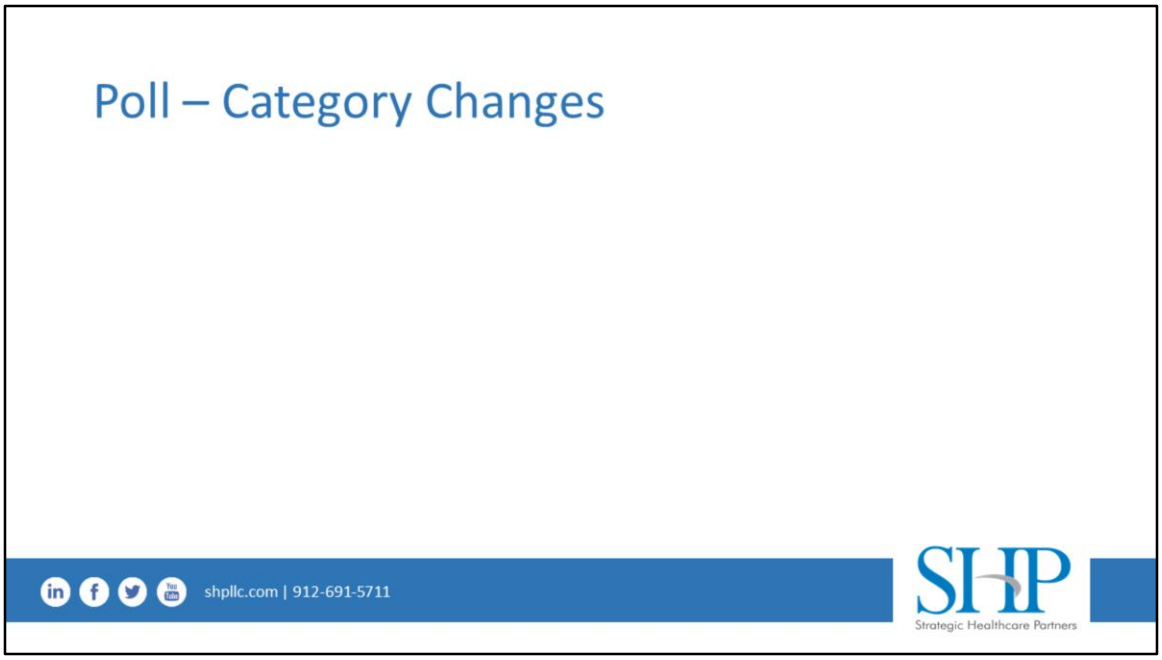
What constitutes a hospital-based clinician group changed from requiring all clinicians in the group to be hospital-based, to 75% of the group instead. This way groups that one or two patient-facing clinicians for follow-ups can still be excluded from Promoting Interoperability.

Also a bit of a technical change, but if you take an exclusion for the Referral Loops measure, the points are added to the Patient Portal measure instead.

If you are auto-excluded from PI in 2019 then PI will still be weighted to 0 in 2020.



No surprises here from the proposed rule, pretty much everything proposed for the QCDR side of MIPS went through. These changes were all something that folks have asked for and generally the public was in support for CMS doing.



What Category Change do you want to know more about?

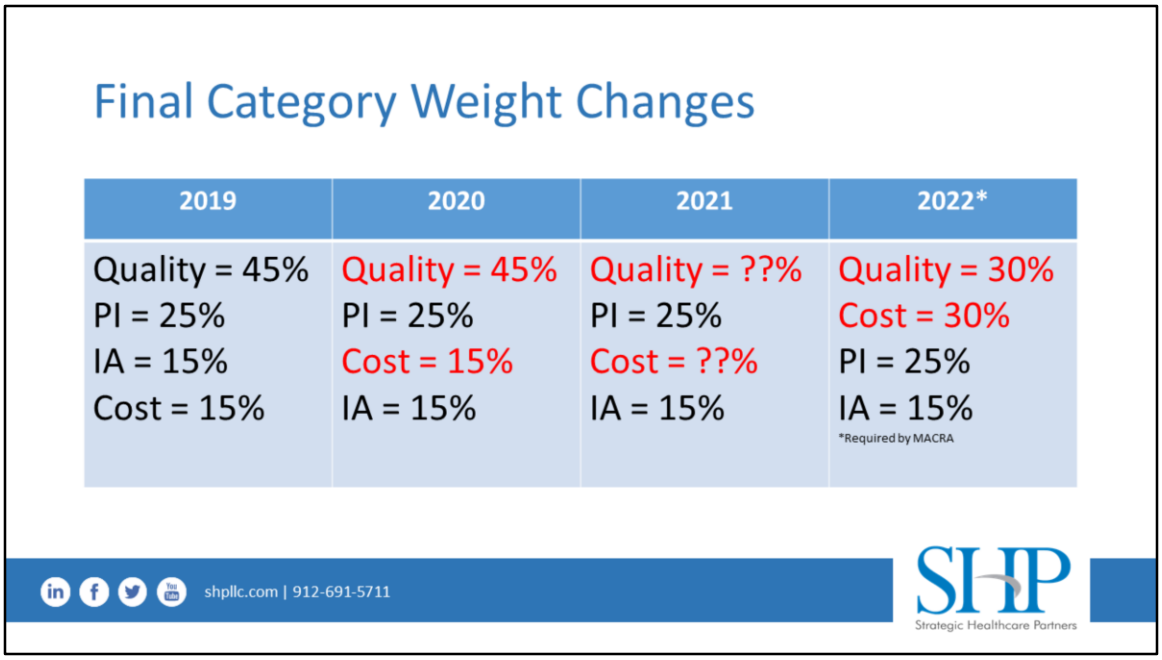
1) Promoting Interoperability
2) Improvement Activities
3) Quality
4) Cost

The scores also received an update, let's go into some further detail about what that means exactly.

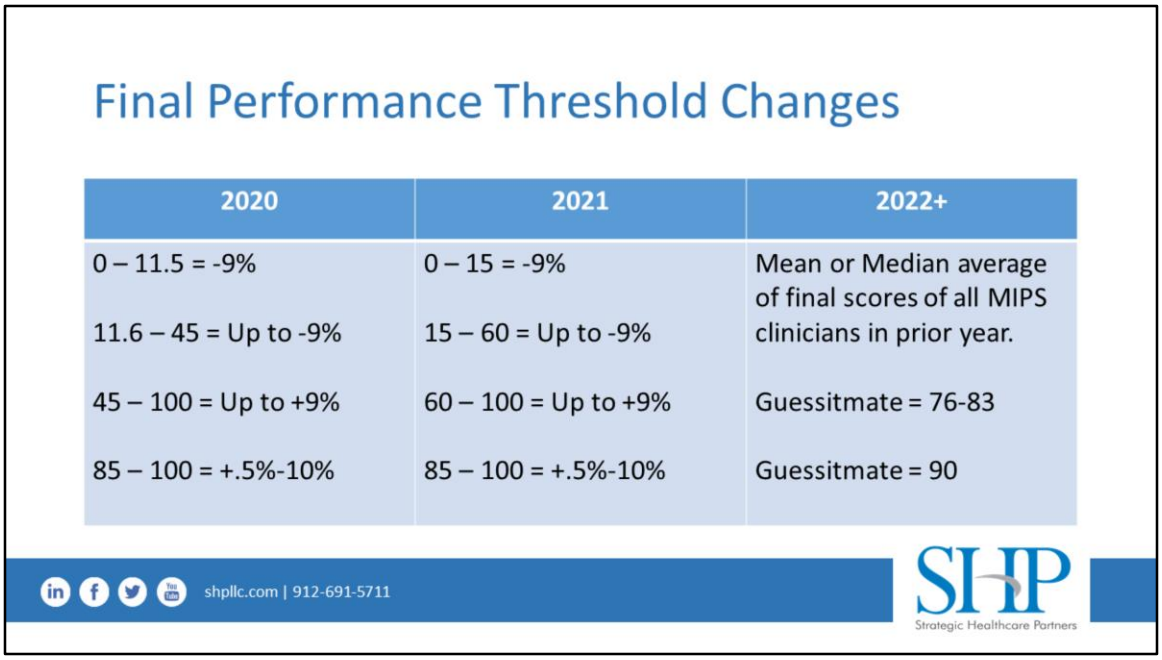
Proposed Category Weight Changes

2019	2020	2021	2022
Quality = 45% PI = 25% IA = 15% Cost = 15%	Quality = 40% PI = 25% Cost = 20% IA = 15%	Quality = 35% PI = 25% Cost = 25% IA = 15%	Quality = 30% Cost = 30% PI = 25% IA = 15%

In the proposed rule, CMS planned on bringing Cost to the forefront by taking 5% from Quality and putting it on Cost every year for the next three years. However…

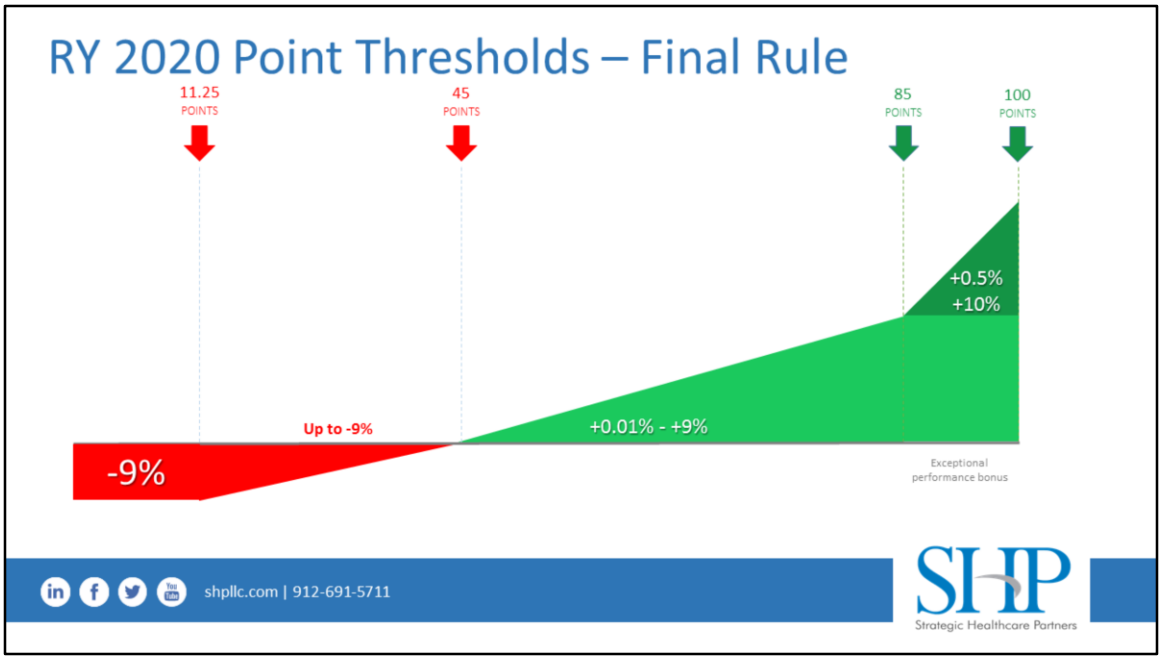


Despite making a big deal about it in the proposed rule, CMS is **not** changing the weights until 2021. The admission in the final rule is that CMS recognizes that the Cost category is too opaque and practices are unable to take action from the data provided. CMS is looking at ways to make the data more actionable and available to providers BEFORE the end of the reporting year. They better move fast because the weights are mandated by law to be increased to what you see here by 2022 .

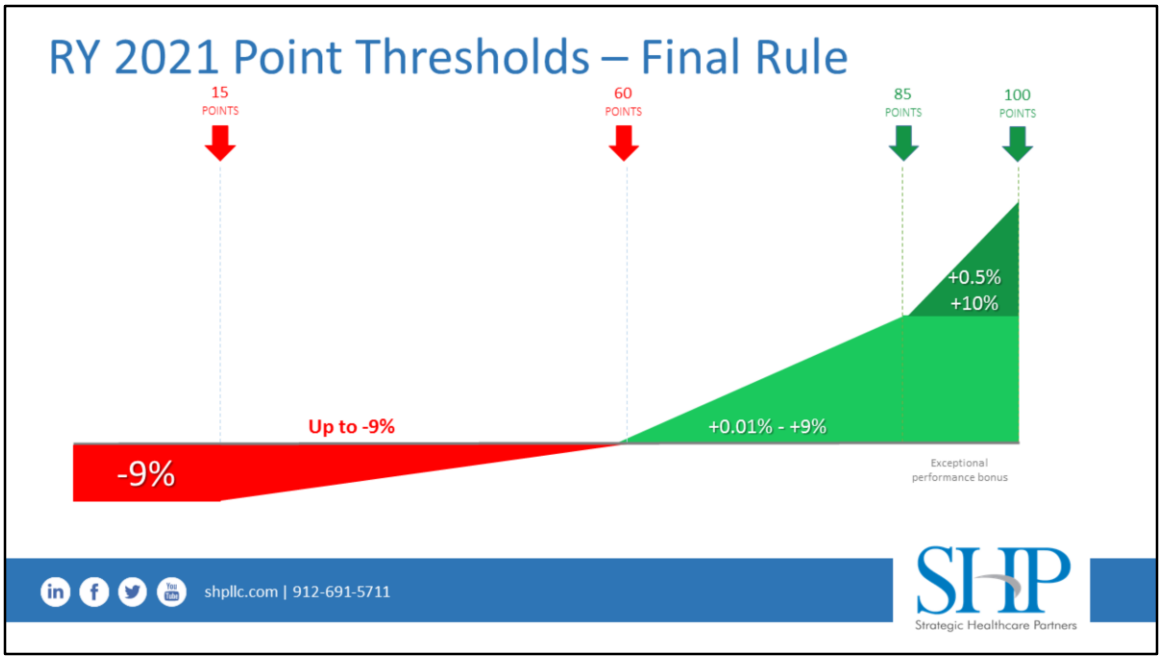


Starting in 2020, if you want to avoid a penalty, you must have a score of 45 or higher. In 2021, that goes to 60. The exceptional performance bonus starts at 85 in both 2020 and 2021. It was proposed to be 80, but CMS felt after looking at the averages, that they needed the higher number.

Starting with the 2022 Final Rule, due Q4 of 2021, CMS will set the performance thresholds at either the mean or median average of prior years' scores of all MIPS clinicians. I would expect to see the exceptional performance level go above 90 as a result.



Here's the change illustrated out in a graph. The ramp, you see is getting shorter…


RY 2021 Point Thresholds – Final Rule
15
POINTS
60
POINTS
85
POINTS
100
POINTS
+0.5%
+10%
Up to -9%
+0.01% - +9%
-9%
Exceptional
performance bonus
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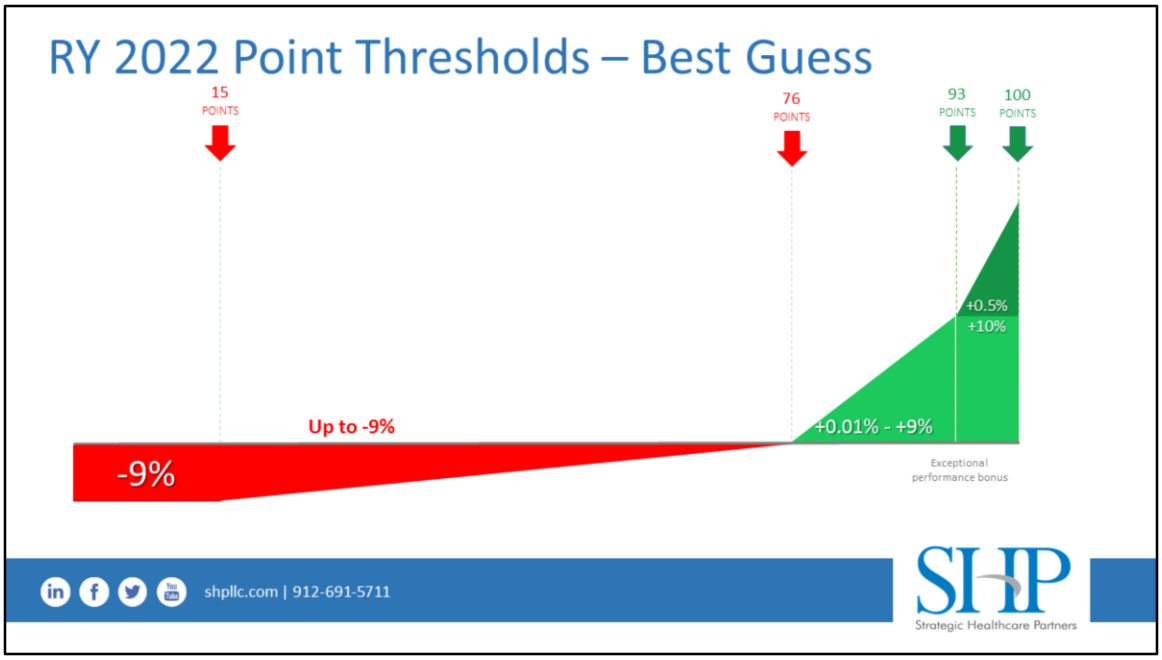
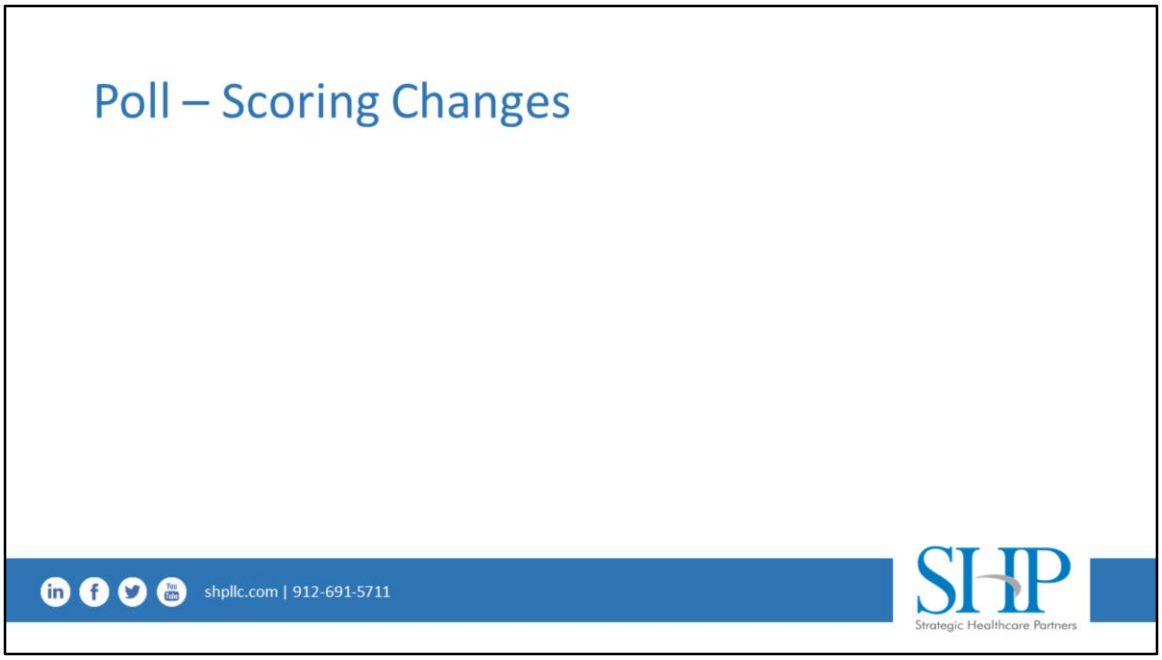
…and shorter



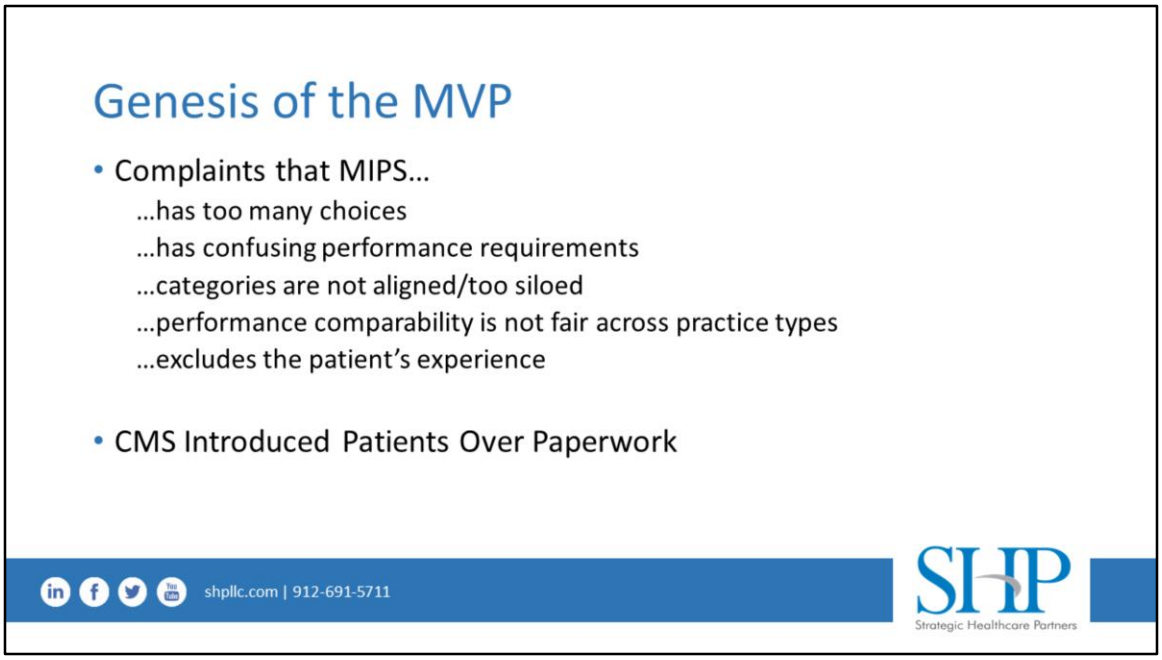
…and shorter. This is what I am guessing we'll see, this is based on the averages that CMS published in the final rule. So be prepared to have to be an extremely high performer to get the maximum return in 2024.



With these scoring changes, do you think your practice will…

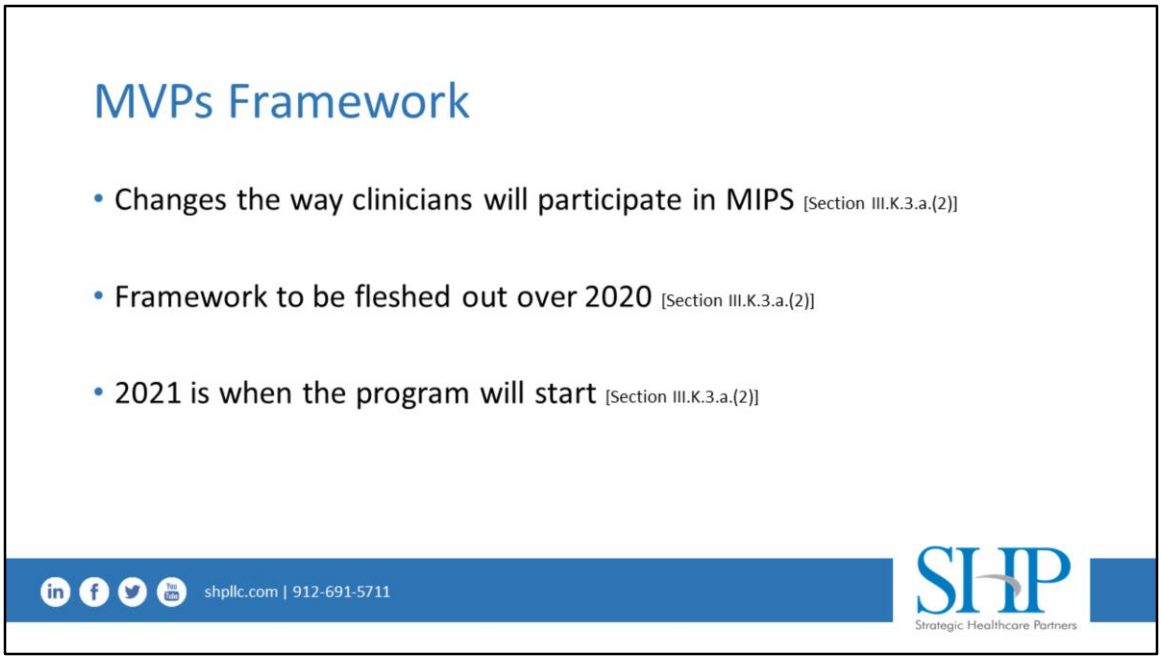
1. Achieve exceptional performance every year
2. Achieve minimums, but not reach exceptional
3. Barely achieve minimums
4. Miss minimums

CMS loves their initialisms, and nothing is safe, not even MVP. The new MIPS Value Pathways program is a shift from the smorgasbord approach we're used to now.



CMS has heard loud and clear that MIPS is scary and confusing. In both the proposed and final rule, they list out the most common complaints, that you see here, that drove their decision to make a drastic change to the MIPS program.

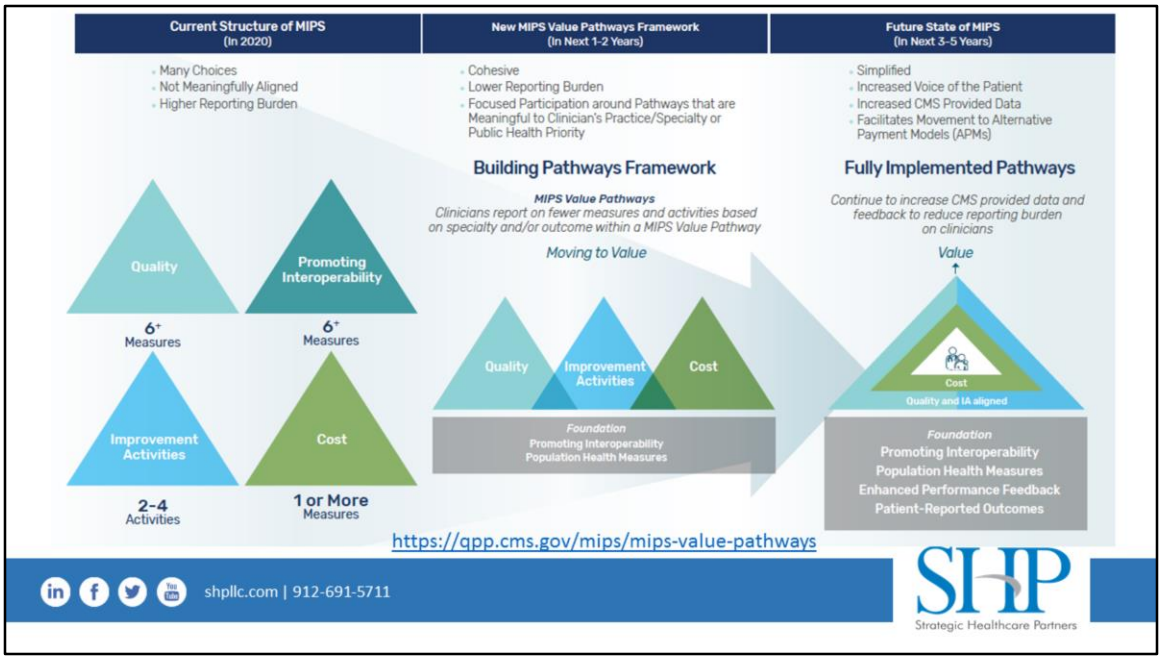
In late-2017, CMS introduced the Patients Over Paperwork initiative, this created a steering committee that led several workshops around the country to find a way that clinicians could still participate in QPP, as required by law, but make it so they aren't as focused on it. Working with private practice, hospitals, and advocacy organizations, the steering committee created the MVP Framework.



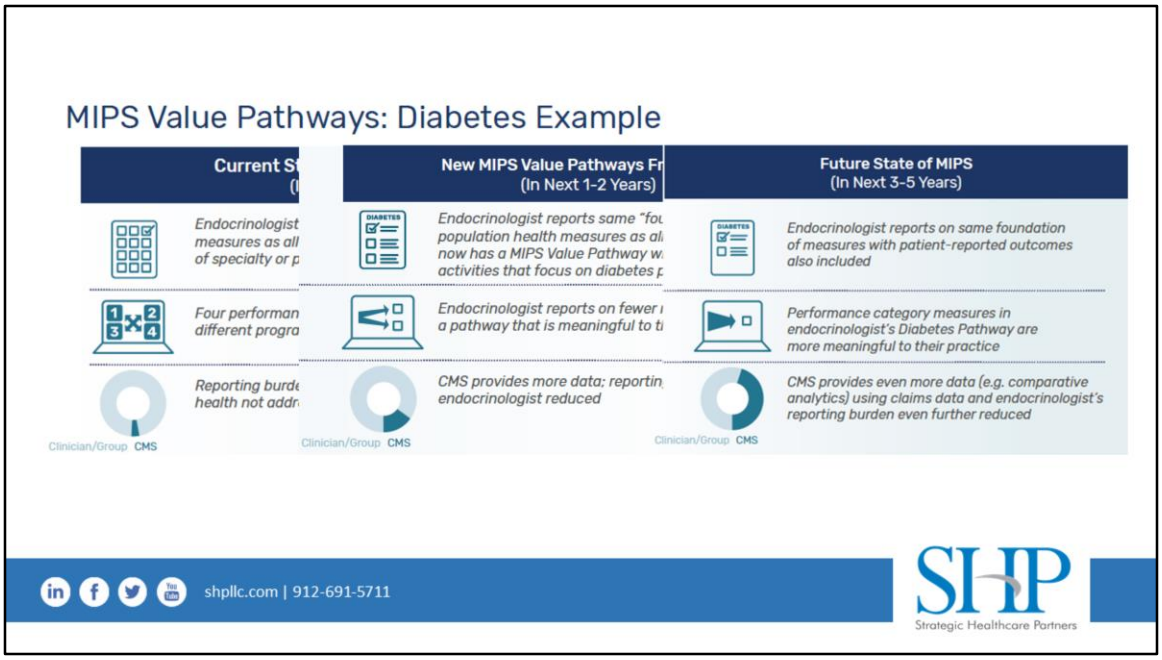
While the design of the MVP program is still in its early phases. The idea of the program is to streamline the options providers have to participate. By narrowing down the measures to those that apply to the clinician type that is participating in the MVPs.
Essentially, CMS will package all MIPS measure into a single bundle to make it easier for a clinician to participate without having to pick all the measures and worry about what does/does not apply to them. This will also allow CMS to weigh measures across clinician types more accurately.

CMS knows that this program needs some growth, so they're starting with a handful of taxonomy types and then growing it out to more and more types. Over the next year, they'll add more types to the MVPs.

As of right now, the MVPs program will be optional, but it may become *the* only way to participate in MIPS. Consider the 2021 implementation date as a soft-launch of the idea. If it works well, we'll likely see it become the one and only way to participate in MIPS.

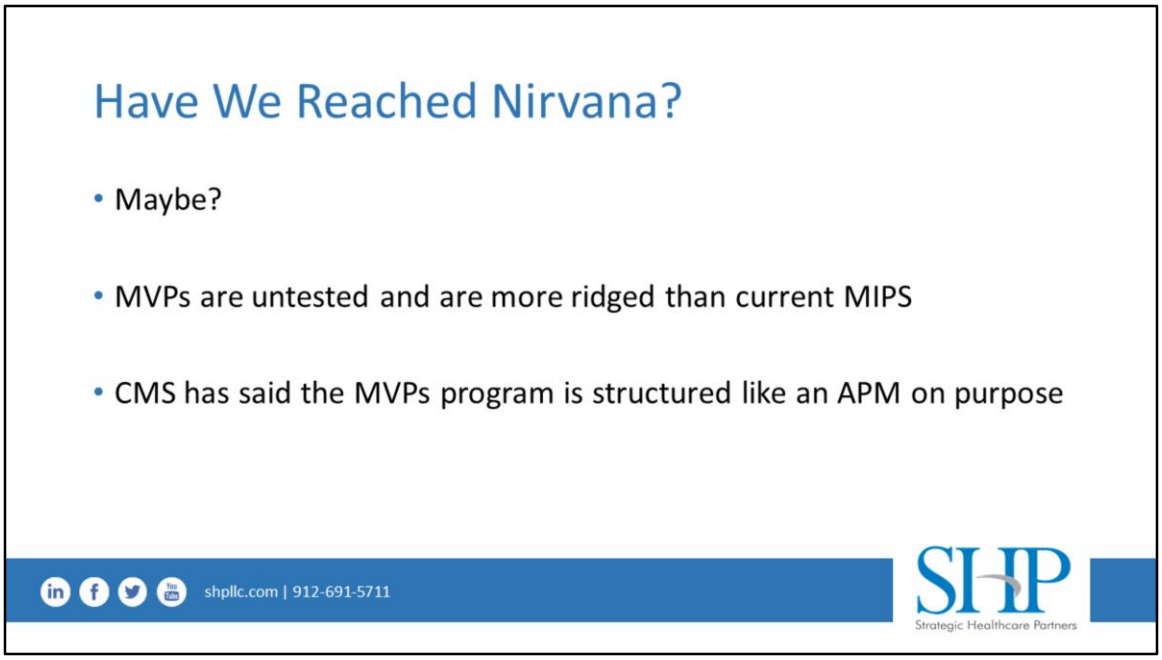


A helpful-ish document, CMS released to show what they're aiming for with the MVP. This chart is available at the link posted here. If this isn't clear, they have some specific provider examples, let's dig into one.



CMS provided an example, in this case they call it the Diabetes Example…

1. CMS highlights the current structure of MIPS as being confusing, siloed and a burden to clinicians
2. In the MVPs, they say, during the transition year, this will be easier as there are now fewer measures the endocrinologist reports on (with several more claims-based measures introduced).
3. In the future, after the MVP program is in full-swing, CMS believes that the endocrinologist's measures will be less burdensome as they will be more relevant and more behind-the scenes.

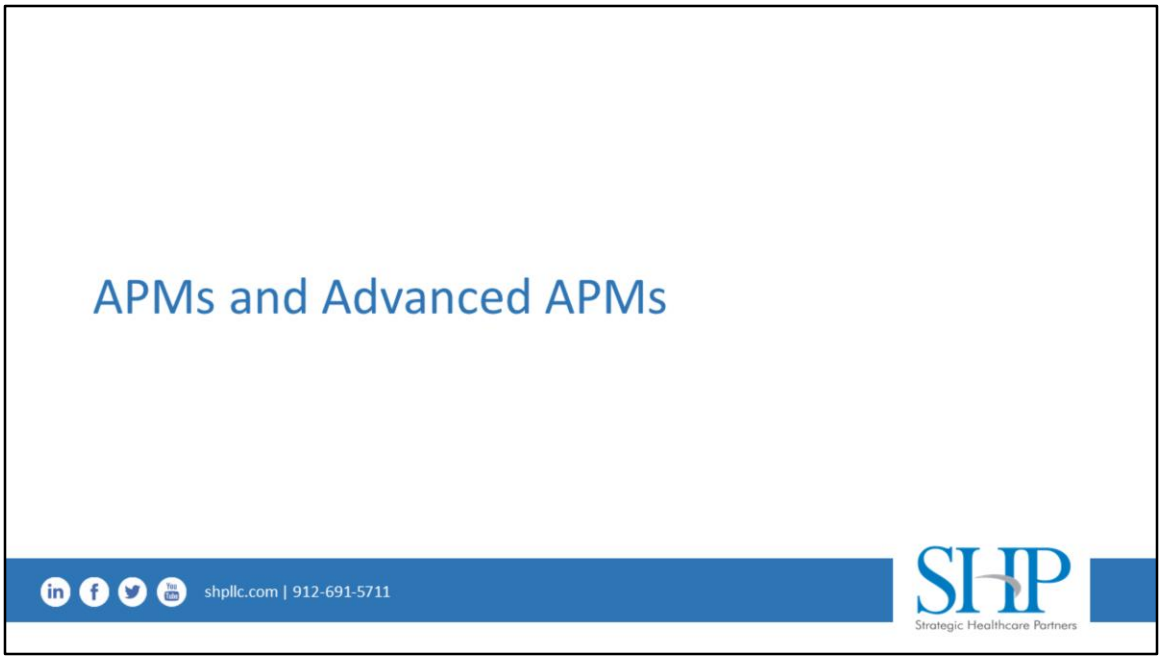


Don't expect the MVPs to be rainbows and unicorns, the program does have some admirable goals, mainly reducing the work a clinician has to do in the exam room with the patient. However, it does not eliminate all of the burden. Ensuring coding is as accurate as possible, for example, becomes a higher-priority. HCC codes are going to be a key factor in this to ensure patient's conditions are being properly tracked and risk-adjusted, the right G-codes are used, etc.

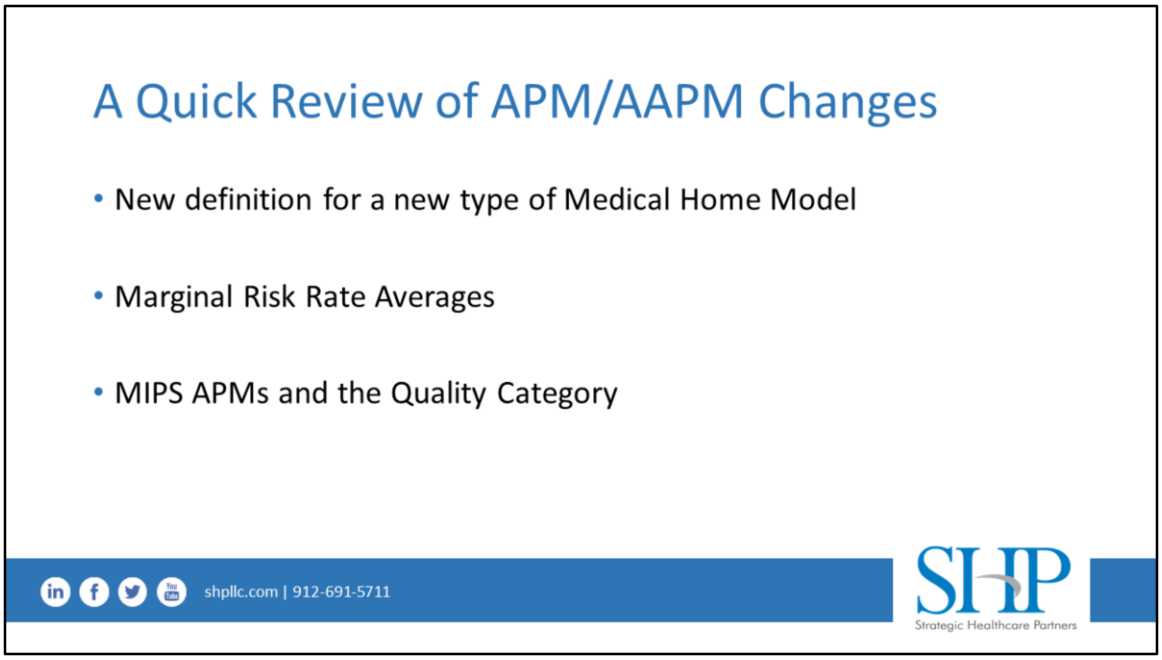
That said, the MVPs are untested, right now it is a working idea. So the next few years will see if clinicians actually any real-world benefit from the program as it is proposed. With any sort of federal program, there will be changes, so don't expect this to appear exactly the same way after year one.

Finally, if this sounds like an APM, where you have to follow certain rules and perform certain metrics, don't be shocked. CMS said in the final rule that they took the design of these more ridged programs and intentionally modeled MVPs after those.

Speaking of APMs, the final rule does have something to say about them.



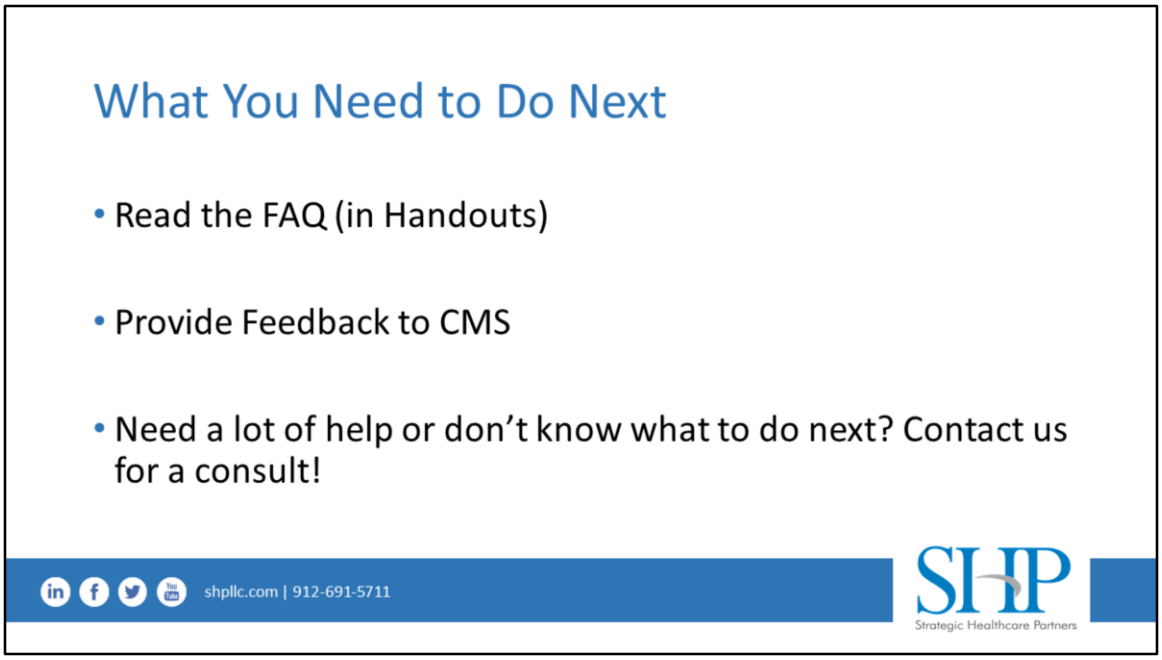
We'll just very quickly touch on these changes to APMs and Advanced APMs…



CMS finalized a new definition that allows for other payers, in other words non-Medicare, to participate in the Medical Home Model with Medicare as an option. The Final Rule sets the structure of what this new MHM looks like.

Second, they have set the marginal risk rate for an APM to be a risk rate across all possible levels of actual expenditures. If that doesn't make sense to you, don't worry, its means that CMS has fixed a flaw in the original risk rate formula for APMs.

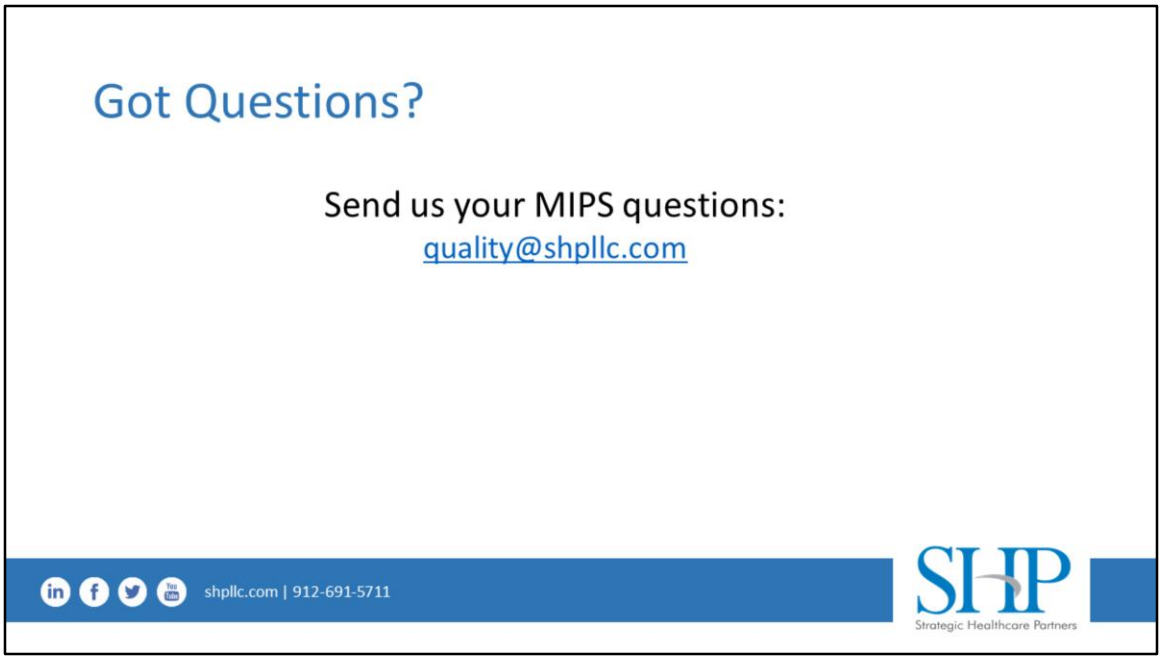
Finally, for MIPS APMs, clinicians can now report their Quality independently of the MIPS APM they belong to. If the clinician is scoring better than the MIPS APM, the clinician can opt to submit a higher score.



I know this was a massive info dump, there are a lot of changes to try to keep track of. The good news is CMS has released some good documents to help answer your questions.

But they're also continuing to ask for feedback and input, particularly around the MVPs and the Promoting Interoperability category. Expect to see them host listening forums, both in-person and online, so-called "office hours" where you can call and talk to someone at CMS, and work with organizations like the AMA and others.

Finally, if you're now realizing that you're in a pickle and need some help with your 2020 plan, please reach out to us. We'd be more than happy to setup a meeting to discuss what you might need to do to be successful.



We have a few extra moments to answer any questions you have.