Welcome – Day One of 3rd Annual Fall Users Conference

Host: Chris Pennington, Marketing Strategist
October 6th-7th 2016
Asheville, North Carolina

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Geriatric Practice Management Staff and Presenters

Presenters

Rod Baird, President

Michael Healey, Chief Operating Officer

Ted Van Duyn, Chairman of the Board

Dr. Kenneth Kubitschek MD, CMD, FACP, CMO

Amy Hajek, Product Manager

Kerri Slattery, Business and Technical Analyst

Jenny Liljeberg, Regulatory Affairs Manager

Mikell J. Clayton, Regulatory Compliance Specialist

Sean E. Smith, Systems and Security Manager

Chris Pennington, Marketing Strategist

Staff

Laurel Woody, Client Services Manager

Tricia Julian, Marketing and Communications Manager

Tiffany Strong, Accounting Specialist

Michael Lahusky, Technical Support Specialist

Will Stokely, Implementation Specialist

Christy Bailey, Implementation Specialist

Austin Snow, Marketing and Sales Operations

Caroline Harris, Administrative Assistant

Devlin Cashman, Systems Administrator

Erik Fann, Customer Support

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Opening Remarks

Ted Van Duyn, Chairman of the Board

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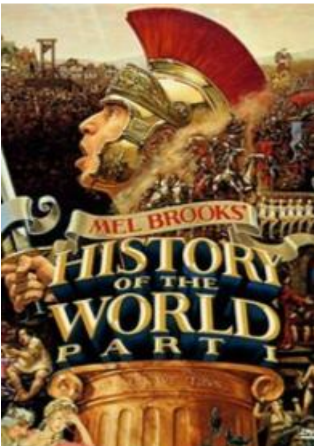
The History of Meaningful Use
A Biography of a Series of Unfortunate Events

Mikell J. Clayton, Regulatory Compliance Specialist



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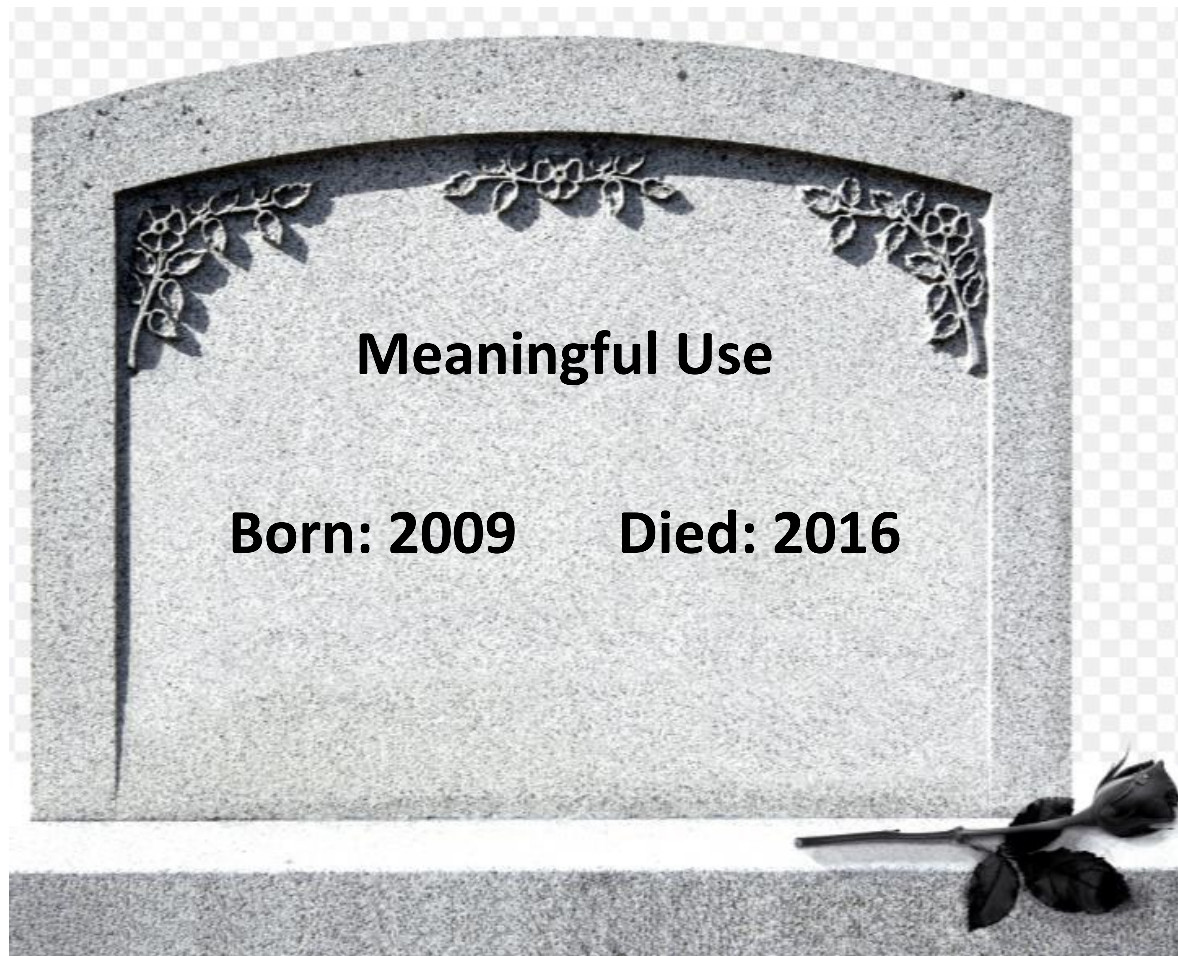
A Moment of Silence for the Bereaved



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In the Beginning….Genesis 1:1

“In the beginning CMS created the rules and guidance. Now before the landscape was formless and empty. Then CMS said let there be endless regulations, and then there was regulations. CMS called this ‘meaningful use.’ CMS was proud of their creation said that it was ‘good’.”

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History of Meaningful Use…. The Birth- February 17, 2009

- Enactment of the American Reinvestment and Recovery ACT (ARRA) – February 17, 2009

- Enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act
  - Created and authorized $36 billion in incentives

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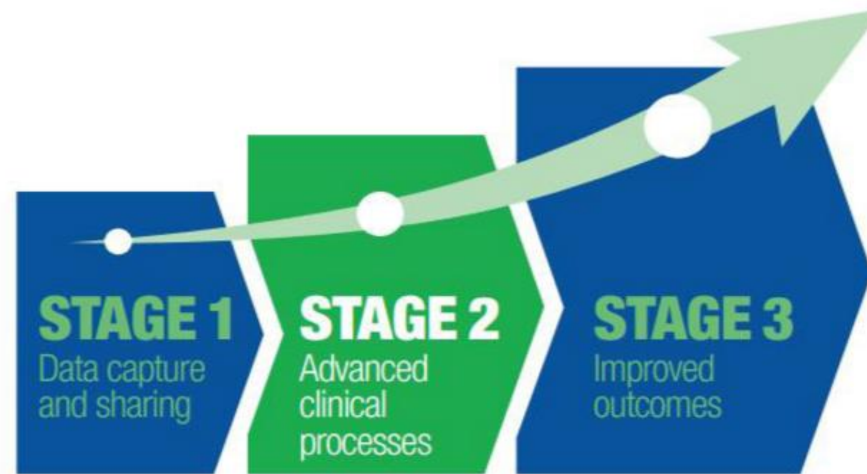
5 'Pillars' of Health Outcomes

1. Improving quality, safety, efficiency, and reducing health disparities
2. Engage patients and families in their health
3. Improve care coordination
4. Improve population and public health
5. Ensure adequate privacy and security protection for personal health information



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Two Roads Diverged in a Yellow Wood

Medicare vs. Medicaid EHR Incentive Payment Program

Medicare EHR Incentive Payment Program	Medicaid EHR Incentive Payment Program
Managed by CMS	State manages its own program
Last year to initiate participation to receive an incentive payment was 2014.	Last year to initiate participation is 2016. Eligible Professionals (EPs) can receive up to $63,750 in incentive payments.
Medicare payment reductions begin in 2015 for providers who are eligible but choose not to participate.	No Medicaid payment reductions for EPs who choose not to participate. Medicare payment adjustments will still apply.
In the first year and all remaining years, providers must meet Meaningful Use objectives and measures.	In the first year, EPs can receive an incentive payment for adopting, implementing or upgrading a certified EHR. In all remaining years, providers must meet the same MU objectives required by the Medicare EHR Incentive program.
Last year of program participation is 2016.	Last year of program participation is 2021.

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Medicare vs. Medicaid

- Medicare EHR Incentive Program

Medicare Incentive Payment Schedule

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 and later
CY 2011	$18,000				
CY 2012	$12,000	$18,000			
CY 2013	$8,000	$12,000	$15,000		
CY 2014	$4,000	$8,000	$12,000	$12,000	
CY 2015	$2,000	$4,000	$8,000	$8,000	$0
CY 2016		$2,000	$4,000	$4,000	$0
TOTAL	$44,000	$44,000	$39,000	$24,000	$0

- Medicaid EHR Incentive Program

Year	*Medicaid EPs Who Adopted In*					
	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

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2011- Meaningful Use Stage 1

Incentive payments began in 2011.

- First year of participation for Meaningful Use Stage 1.
  - Focused primarily on adoption, data gathering, and sharing.
  - Consisted of 13 core objectives, 5 Menu Measures, and 9 CQMs
- Per ONC, Approximately 58k health care professionals attested for MU in 2011

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2012

- On August 23, 2012 CMS and ONC released that final requirements for Meaningful Use Stage 2 which delayed performance for EP’s to January 1, 2014.

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2013

- Final year that providers could attest for only Stage 1

- As of May 2014, 9 out of 10 providers who attested to Meaningful Use in 2011 attested again in a following year.
  - Of the 16% of providers that skipped their second year (2012), 43% returned to the program in 2013. 9% of the initial cohort skipped both 2012 and 2013.

KEEP CALM RESISTANCE IS FUTILE

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2014- Meaningful Use Stage 2

- Providers who began in 2011 began to attest for Stage 2

- Stage 2 was increasingly more difficult to achieve. Stage 2 consisted of:
  - Higher Thresholds then previous Stage 1
  - Extended CEHRT capabilities
    - 17 Core Objectives
    - 6 Menu Objectives.

- Stage 2 was disastrous-Nearly unachievable. Only 10 U.S hospitals had attested by July of 2014.

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2015- Modified Stage 2

- First year that penalties were accessed.
- Introduction of Modified Stage 2 in October of 2015.
- Consider this to be CMS' *Mea Culpa*

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2016- Meaningful Use Admitted to Hospice Care.

- "Meaningful Use program as it has existed will now effectively be over…"

  -Andy Slavitt, January 14, 2016

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2017- The Zombie Effect

- Meaningful Use has been resurrected and continues on in 2017 under MIPS as "Advancing Care Information."

- Reporting requirements dependent upon EHR's ONC certification.

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2018 and Beyond- Meaningful Use Stage 3?

- “Don’t get fooled Again!”- Meaningful Use will continue to exist in some form.
- Advancing Care Information will supersede MU under MACRA
  - Customizable measures, but still complex.
- 2015 EHR Certification required!
  - Aligns with Meaningful Use Stage 3.
  - Thresholds to return
  - More guidance expected with the publication of the final rule.

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Past Behavior Often Times Dictates Future Outcomes.

- CMS will build upon previous Meaningful Use requirements.
- The hallmarks of MU will continue to exist-care coordination, patient engagement, and information exchange
- Stakeholder feedback is crucial in the rule-making process.
- Though CMS will add some flexibility in MIPS; it is possible to fail.

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The More Things Change….The More They Stay The Same

- Of all iterations and changes to Meaningful Use, the Security Risk Analysis has always been required.

- While gEHRiMed is HIPAA-compliant, we have no control how you design and intend to keep health information secure

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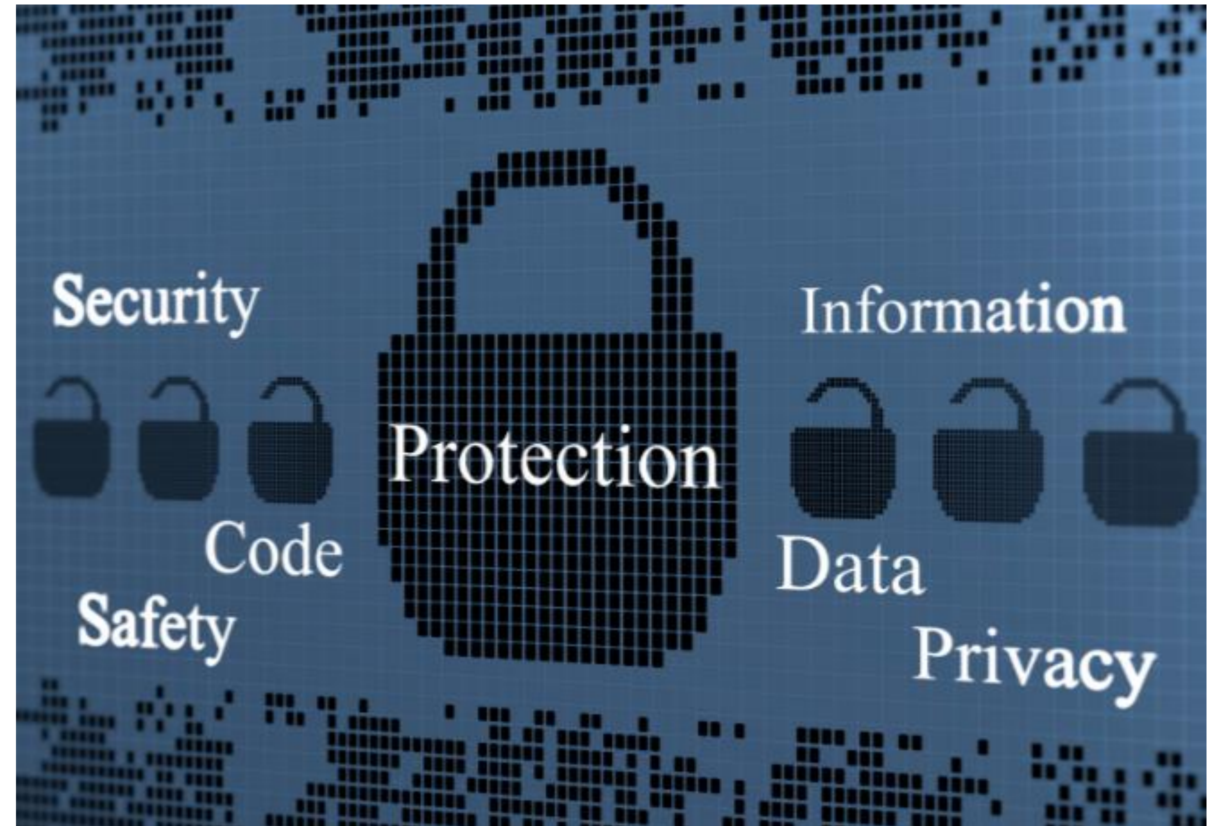
Now you have the history…This is How You Fail 100% of the Time

- Complete failure for providers who do not conduct a Security Risk Analysis.
- Yes! It's that important!



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Questions

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Coffee Break

Presentations will resume at 10:15am

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GPM Cybersecurity Program Overview

Sean E. Smith, Systems and Security Manager

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Definition of terms

- Business Associate Agreement (BAA) – A contract between a HIPAA covered entity (Provider) and a HIPAA Business Associate (BA). The contract protects personal health information (PHI) in accordance with HIPAA Guidelines.

- Risk Assessment vs. Risk Analysis – Risk Assessment is a process which will produce the Risk Analysis documentation.

- SSAE 16 - SOC Level 1 (Statement on Standards for Attestation Engagements No. 16 – Service Organization Controls Level 1) - SOC 1 reports will be geared towards service organizations that are reporting on controls relevant to internal control over financial reporting (ICFR). Type 2 audits test the effectiveness of the controls.

- SSAE 16 - SOC Level 2 (Statement on Standards for Attestation Engagements No. 16 – Service Organization Controls Level 1) - SOC 2 reports will be geared towards service organizations that are reporting on controls relevant to internal control over non-financial reporting (ICFR). Type 2 audits test the effectiveness of the controls.

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Definition of terms (cont.)

- NIST HIPAA Security Rule Toolkit - The NIST (National Institute of Standards and Technology) HIPAA Security Toolkit Application is intended to help organizations better understand the requirements of the HIPAA Security Rule, implement those requirements, and assess those implementations in their operational environment.

- Cybersecurity Framework - The Cybersecurity (or sometimes called Common Security) Framework (CSF) is a set of cybersecurity activities, outcomes, and informative references that are common across critical infrastructure sectors, providing the detailed guidance for developing individual organizational cybersecurity programs. The principal objective is to reduce risks including prevention or mitigation of cyber-attacks.

- HITRUST - The Health Information Trust Alliance, or HITRUST, is a privately held company located in the United States that, in collaboration with healthcare, technology and information security leaders, has established a Common Security Framework (CSF) that can be used by all organizations that create, access, store or exchange sensitive and/or regulated data. The CSF includes a prescriptive set of controls that seek to harmonize the requirements of multiple regulations and standards.

- Penetration Test - Penetration testing (also called pen testing) is the practice of testing a computer system, network or Web application to find vulnerabilities that an attacker could exploit

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Office for Civil Rights Fines for 2016

- Advocate Health Care Network - $5.5 M
  - 4+ millions patients PHI breach
  - Unencrypted laptop stolen
  - Desktop machines stolen from business office
  - BA (billing service) network was hacked and access to ePHI
- Feinstein Institute of Medical Research - $3.9M
  - Stolen laptop – 13,000 patient records
- University of Mississippi Medical Center - $2.75M
  - Stolen laptop – 10,000 patient records
- Catholic Health Care Services - $650K
  - First Business Associate fine!
  - 412 patients – stolen company iPhone

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Top reasons for breach settlements

- Risk Assessment process missing or neglected
- Access controls missing
- Theft of unencrypted device(s)
- End user errors

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MIPS/MACRA Risk Assessment

- Mandated as part of MIPS/MACRA
- Lose reimbursement without documented proof of HIPAA Risk Analysis
  - -4% to -9% over the next several years
- Complete failure of the Advancing Care Information performance Category if Assessment is not completed

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GPM HIPAA Legal Requirement

- Nothing – GPM is not a CMS Covered Entity
  - Health Plan
  - Clearinghouses
  - Medical Groups
- GPM does sign a BAA with medical groups

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GPM Security Practices since inception

- HIPAA Security program since inception
- Annual HIPAA Security Risk Analysis using NST HST Toolkit
  - 2016 GPM will use HIPAAOne Security Risk Analysis tool
- gEHRiMed – Dual factor authentication
- EVERY access, mouse click, anything done in gEHRiMed is recorded in the Audit Log
- Encryption on all devices including servers and backup storage

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GPM Security Practices since inception (cont.)

- Annual external Penetration testing by third party
- 2015 SSAE 16 SOC Level 1 Type 2 Audit by certified external auditing company
- Clients can request copies of Risk Analysis and SOC Documentation through Client Services

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GPM SSAE 16 SOC Level 1 Type 2 Program

- Started testing in July 2015
- 2015 testing period July through December – No findings!
- Penetration testing of system passed with no issues
- Dixon Hughes Goodman LLP auditing firm
- 2016 testing period January through November
- Bridge period December 2016

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GPM Cybersecurity Program Enhancements

- 2017 SSAE 16 SOC Level 2 Type 2
- HIPAAOne Risk Analysis tool
- Monthly vulnerability testing of gEHRiMed and GPM Office
- Implementation of HITRUST Cybersecurity CSF
- Security Blog covering LTPAC Medical Groups

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What are clients responsible for?

- Risk Assessment process – covers more than just HIPAA
- User accounts and passwords
- GPM recommends practitioners use outside consulting services to assist with HIPAA Risk Assessment process
- Reporting unauthorized access in gEHRiMed to GPM as part of the Breach Notification
- gEHRiMed is a tool – LTPAC Medical Groups are responsible for security and process on how the tool is used
- gEHRiMed provides a monthly report of all client users including last date logged on, last password change date and if user is disabled

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GPM Cybersecurity Program client changes

- More regimented in processes and documentation
  - Written policies
  - Documentation to prove our policies are followed
  - Policies are reviewed and adjusted as part of the review process

- Required to document ALL unauthorized access to system
  - ALL unauthorized access is documented and reviewed as part of Risk Assessment process
  - ID and password breaches must be documented and reported to CMS if required
  - ZenDesk ID and passwords forced changes quarterly
  - GPM Client Services can provide Program documentation upon request

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Compliance Consulting Vendor

- HIPAA One

- http://www.hipaaone.com

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Questions?

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Risk Assessment and the Anatomy of a CMS Audit

Steve Marco, President, HIPAA One
Sean E. Smith, Systems and Security Manager

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Why create a Risk Assessment Process?

- MACRA/MIPS demands it
- CMS is allowed to ‘self-fund’ enforcement through fines
- Breach is VERY costly
- HIPAA Rules in place almost 20 years
- Good business practice

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How to create a good Risk Assessment Process

- Identify all areas for compliance – HIPAA, ISO, PCC DSS, etc.
- Identify all areas in common and include in one policy
- Commercial Risk Assessment tool
  - Must cover HIPAA
  - Can use the tool all year long to assist in remediating identified risks
  - Updated with latest in compliance requirements changes
  - Offers expert assistance/consulting

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How to create a good Risk Assessment Process (cont.)

- Generate a risk report to identify areas of need
- Review and determine if all areas covered are needed
- Classify risk level – High, Medium and Low
- Create action plan(s) to address identified risks
- Update tool with information as action plan is executed
- Continue with action plan(s) and repeat process

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LTPAC Medical Groups unique focus

- Mobile, roaming workers
- Instant messaging security constraints
- Cannot control facility staff
- Patient consent
- Very few ‘secure’ spaces for HIPAA conversations
- Handheld device(s) are very rarely updated

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Anatomy of a HIPAA Security Audit

Steven Marco

President and Founder

- **Experience:**
  - Deloitte & Touche (COBIT)
  - Resources Global Professionals (IPO – SOX)
  - 20 years in Audit and IT Engineering, 9 years in H.I.T.
  - Over 2400 sites using HIPAA One® today
  - 100% audits passed

- **Certifications:**
  - Certified Information Systems Auditor (CISA)
  - IT Infrastructure Library (ITIL)

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HIPAA One Sponsored Lunch & Networking

Lunch and refreshments provided in the lobby

Presentations will resume at 1:00pm

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Demystifying MIPS

Rod Baird, President
Jenny Liljeberg, Regulatory Affairs Manager
Mikell J. Clayton, Regulatory Compliance Specialist

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GPM Regulatory Team

- LTPAC Providers → Priority.
- Voice our concerns to the powers that be (CMS, ONC).
- Making sure that the speed at which CMS is churning out new payment models and value based strategies, that the gEHRiMed software will always be able to meet the evolving needs of the LTPAC community.

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Medicare Access and CHIP Reauthorization ACT of 2015 (MACRA)

- Repeal flawed Sustainable Growth Rate (SGR) Formula, aka ‘Doc Fix’
- Transition to reward clinicians for value over volume
- Offer multiple pathways to avoid negative reimbursements.

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MACRA Facts

- 50% of surveyed physicians have never heard of the MACRA Legislation.
- 8 out of 10 physicians said they prefer traditional fee-for-service.
- 58% of physicians said they would opt to be a part of a larger organization to reduce individual increased financial risk.

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Linking Two Worlds - MIPS and Medicare B circa 2016

QUALITY @ 50%

PQRS & Quality Score from VBP

CLINICAL PRACTICE IMPROVEMENT @ 15%

Update of Maintenance of Certification

New Category in 2017

RESOURCE USE @ 10%

Cost Component from VBP

ADVANCING CARE INFORMATION @ 25%

Previously Meaningful Use

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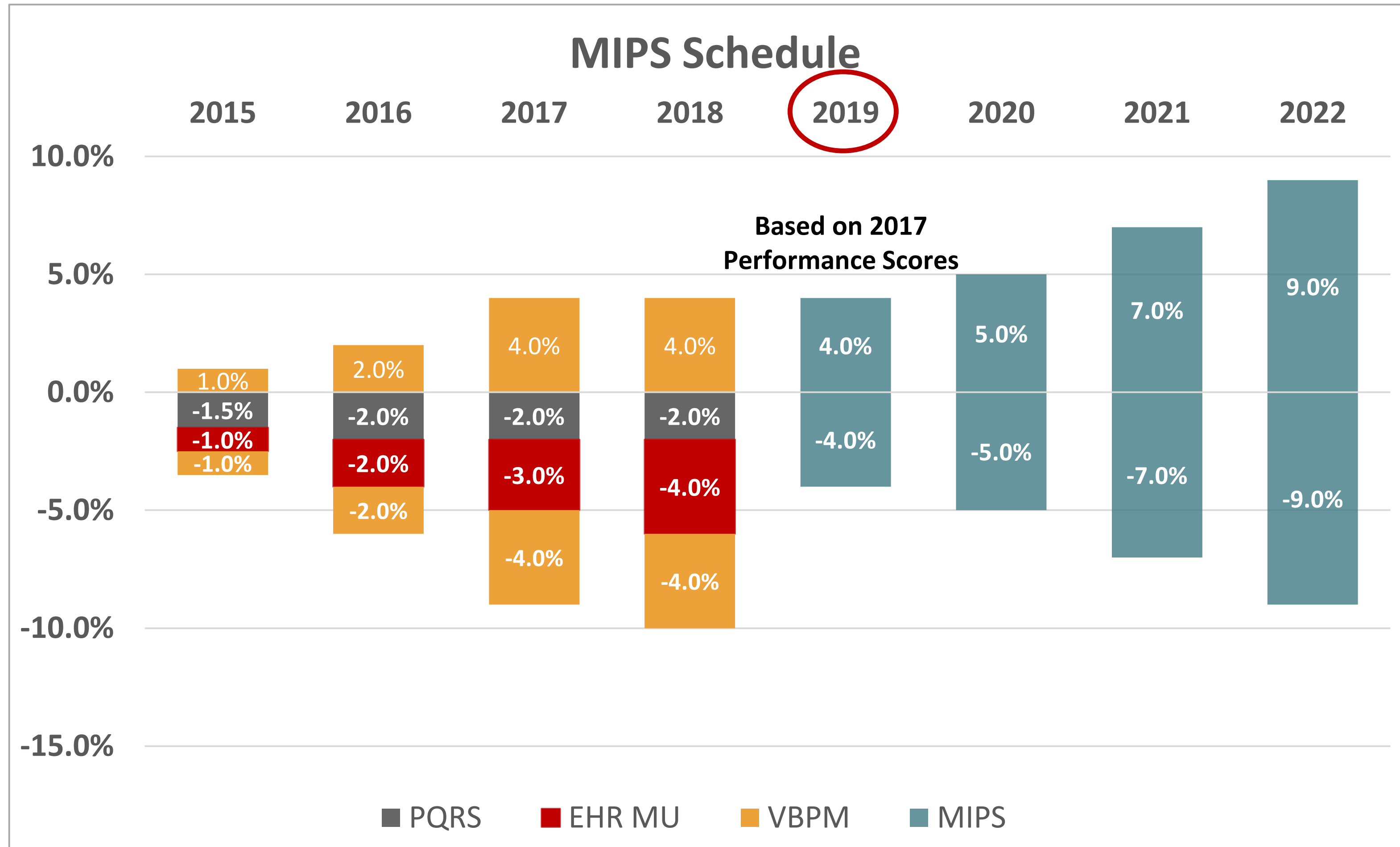
MIPS Schedule



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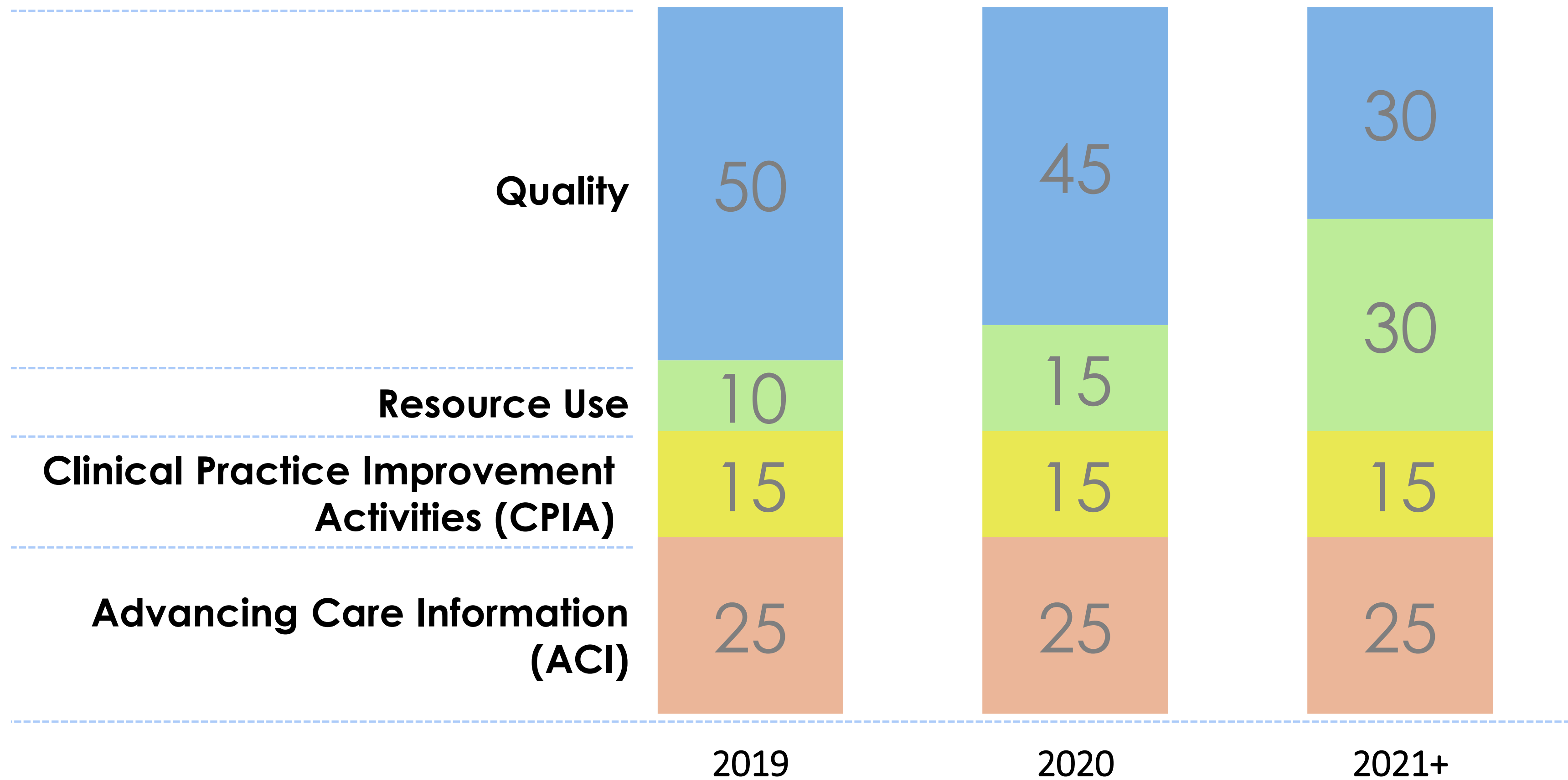
MIPS Components: Relative Weight Over Time



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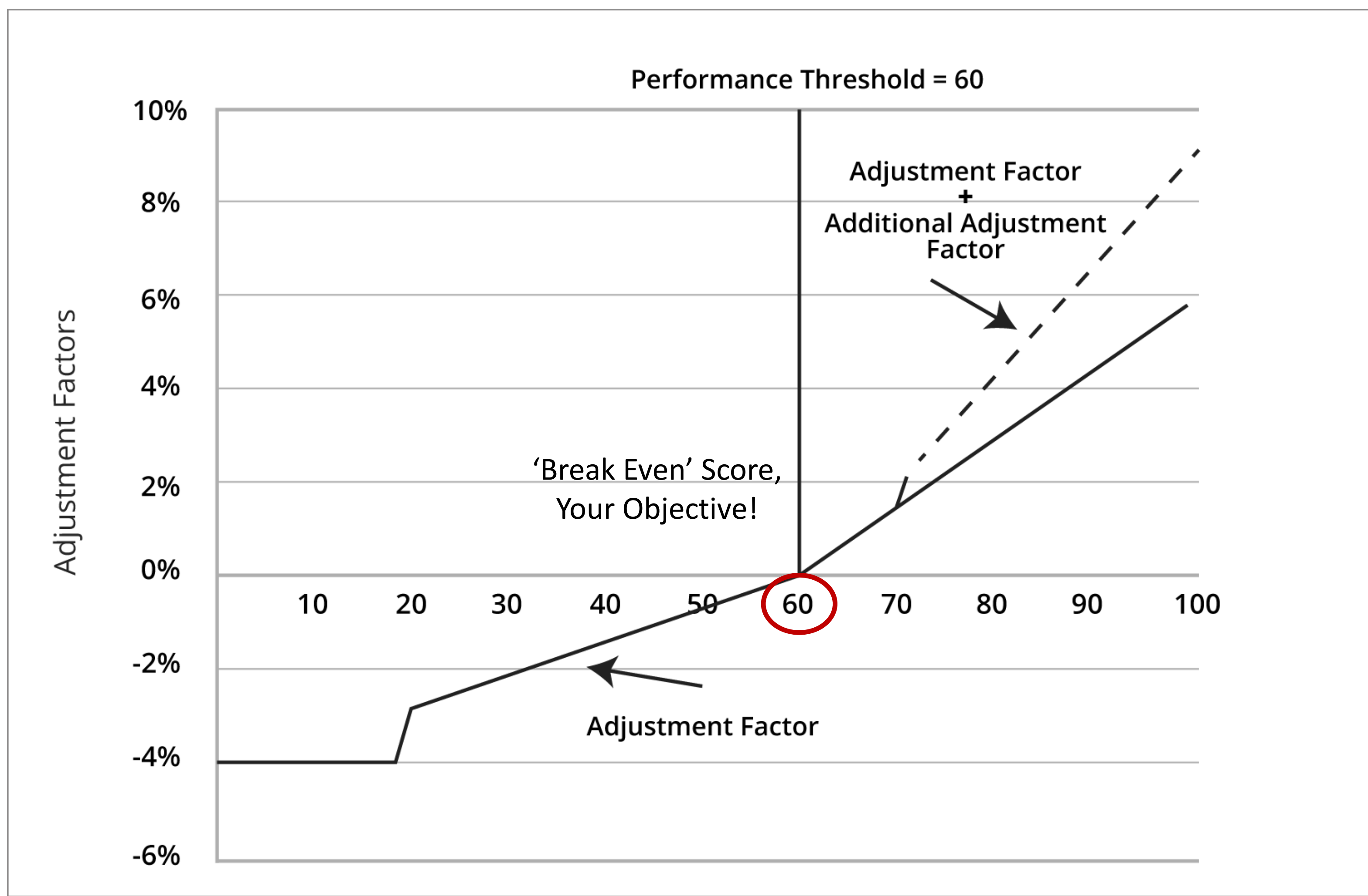
MIPS Adjustment Factors Based on Composite Performance Scores ?



- Score below 'Break Even' point (60), pay a penalty
- Score above 'Break Even' point (60), earn incentive money
- Below the 'Break Even' Point (Penalized)
  - ¼ of the bottom half (1/8 of total players), receive flat 4% penalty.
  - The rest have a gradually decreasing penalty until the 'break even' point.
- Above the 'Break Even' Point (Rewarded)
  - Gain incentive bonus linearly

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MIPS Scorecard

Quality			Advancing Care Information			Clinical Practice Improvement			Resource Use		
Measure	**Max value**	**Score**	**Objectives**	**Possible points**	**Score**	**Activity**	**Possible Points**	**Score**	**Measure**	**Possible Points**	**Score**
1 –Outcome Measure	10		Protect PHI			#1 – High					
2 – Cross-Cutting Measure			eRx			#2 – Medium					
Measure # 3	10		Patient Access			#3 – Medium					
Measure #4	10		Coordination of Care			#4 – Medium					
Measure #5	10		HIE			#5 – Medium					
Measure #6	10		Reporting to Public Health								
CMS – 1 (Acute Composite)	10										
CMS-2 (Chronic Composite)	10										
CMS-3 (All Cause Rehospitalization)	10										
Total Points			**Total Points**			**Total Points**			**Total Points**		
Weighted Score			**Weighted Score**			**Weighted Score**			**Weighted Score**		

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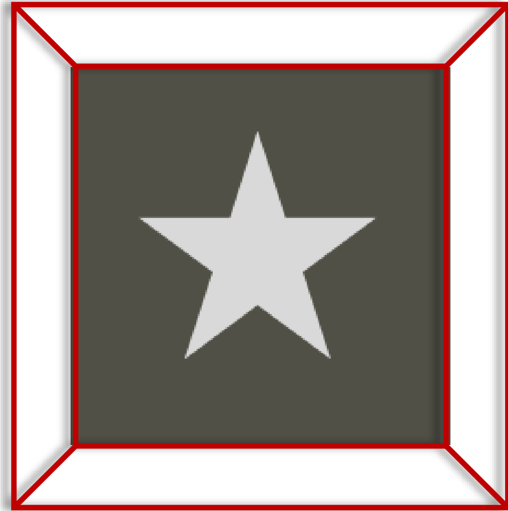
MIPS Components: Quality Deep Dive

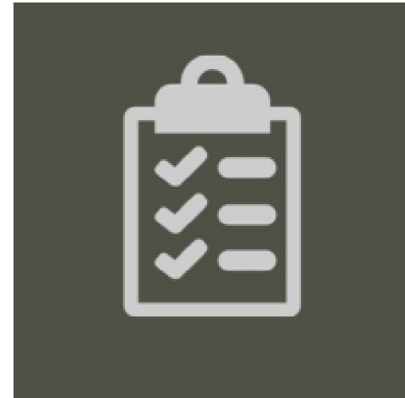


50%

Quality

10%

Resource Use



15%

Clinical Practice Improvement Activities

25%

Advancing Care Information

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Quality Component Characteristics: PQRS vs. MIPS

Existing	Future
9 Measures, or 1 Measures Group, or GPRO Web	6 Measures (1 Cross-cutting; 1 Outcomes Measure)
Domain Reporting	Eliminated
Some methods require only partial patient volume (e.g., measures groups, registry)	Report on 90% of all eligible patients
Neutral financial impact for ± 1 Std. Deviation	No possibility of neutral impact
Single measure benchmark across all reporting methods	Each reporting method has its own benchmark
Requirement to declare GPRO reporting by June 30th	No declaration required* *except GPRO web-interface and CAHPS

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MIPS Components: Quality Deep Dive

Quality				
Measure	**Max value**	**High Priority Bonus Points**	**Data Capture via CHERT?**	**Score**
1 –Outcome Measure	10			
2 – Cross– Cutting Measure	10			
Measure # 3	10			
Measure #4	10			
Measure #5	10			
Measure #6	10			
CMS – 1 (Acute Composite)	10			
CMS – 2 (Chronic Composite)	10			
CMS – 3 (All Cause Rehospitalization)	10			
Total Score				
Weighted Score				

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MIPS: Quality Component
(Currently PQRS)

Quality @ 50%		
Measure	**Max value**	**Score**
1 –Outcome Measure	10	
2 – Cross-Cutting Measure	10	
Measure # 3	10	
Measure #4	10	
Measure #5	10	
Measure #6	10	
CMS – 1 (Acute Composite)	10	
CMS – 2 (Chronic Composite)	10	
CMS – 3 (All Cause Rehospitalization)	10	
Total Points	90	
Weighted Score		

- 50% of MIPS Composite Score
- 300+ Measures Listed
- Only 40 Measures Related to SNF/NF
- 3 Measures Mandated by CMS

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CMS Quality Scoring for Hospital Admissions/Readmissions

QRUR Report Data

QM:	MIPS Score:
CMS -1	1-3
CMS -2	1-3
CMS -3	1-3

PQRS Meaure Number and Name	Your Performance		Peer Group Performance			Contribution to Your Domain Score	
				Average Range			
	Eligible Cases	Performance Rate	Benchmark Rate	Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions							
CMS-1** Acute Conditions Composite (links to data table)	3,255	19.79	8.38	1.99	14.77	-1.79	No
- PQI-11 Bacterial Pneumonia**	3,255	29.49	12.37	1.66	23.08	-	-
- PQI-12 Urinary Tract Infection**	3,255	19.84	8.11	0.00	16.76	-	-
- PQI-10 Dehydration**	3,255	9.99	4.61	0.00	9.61	-	-
CMS-2** Chronic Conditions Composite (links to data table)	2,186	57.96	54.02	26.82	81.22	-0.14	No
- Diabetes (composite of 4 indicators)**	1,204	54.84	18.94	0.00	39.27	-	-
- PQI-5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma**	975	60.70	78.06	28.12	127.99	-	-
- PQI-8 Heart Failure**	1,331	96.13	100.70	48.52	152.89	-	-
Hospital Readmissions							
CMS-3** All-Cause Hospital Readmissions (links to data table)	2,061	16.39%	16.43%	14.99%	17.86%	0.02	No

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6 Quality Measures: Achieve CMS's Criteria for SNF/NF Care

Measure Title	POS	MIPS Measure Type	Bonus Points	Benchmark Registry 2014 Mean
Diabetes: Hemoglobin A1c Poor Control	31, 32, 13	Intermediate Outcome, High Priority	2	**28.44%**
Care Plan	31,32,13	Process, High Priority, Cross-Cutting	1	**57.82%**
Influenza Immunization	31,32,13	Process		**47.75%**
Falls: Risk Assessment	31,32,13	High Priority	1	**38.78%**
Adult Sinusitis: Appropriate Choice of Antibiotic:	31,32,13	Process, High Priority, Appropriate Use	1	**41.92%**
Body Mass Index (BMI) Screening and Follow-Up Plan	31, 32, 13, 14, 33, 54, 12	Process, Cross-Cutting		**63.92%**

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Full Quality Score Card – 9 Quality Measures

Measure	Max value	High Priority Bonus Points	Data Capture via CHERT?	Benchmark Registry 2014 Mean	Your Score	Points
Diabetes: Hemoglobin A1c Poor Control	10	2	1	**28.44%**	30%	5+3
Care Plan	10	1	1	**57.82%**	95%	9+2
Influenza Immunization	10		1	**47.75%**	95%	9+1
Falls: Risk Assessment	10	1	1	**38.78%**	90%	10+2
Adult Sinusitis: Appropriate Choice of Antibiotic:	10	1	1	**41.92%**	50%	4+1
Body Mass Index (BMI) Screening and Follow-Up Plan	10		1	**63.92%**	90%	8+1
					Subtotal	[55]
CMS-1 –Acute Conditions Composite	10				2	2
CMS-2 – Chronic Conditions Composite	10				5	5
CMS-3 – All Cause Rehospitaliztions	10				6	6
Total Score	90				Total	68
Weighted Score	50%		(68/90)x50%			**38%**

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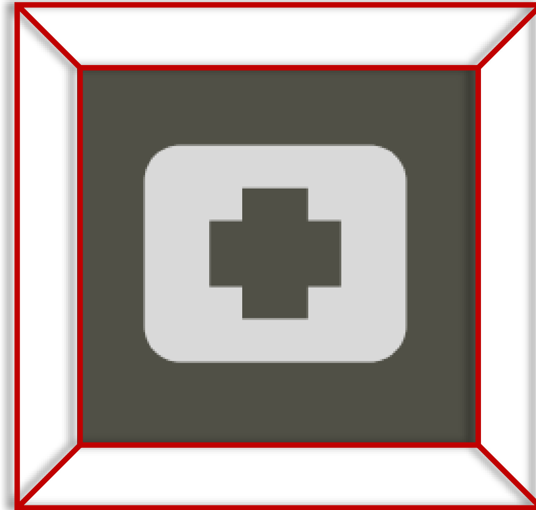
MIPS Components: Quality Deep Dive

50%

Quality



10%

Resource Use

15%

Clinical Practice Improvement Activities

25%

Advancing Care Information

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Changes in the Attribution Methodology Under MIPS

VBP (2012 -2016)

- Patient Attribution based on plurality of care:
  - *Based on Primary Care Encounters (if present)*
  - POS 31 and 32 Both Considered as Primary Care
  - Nearly 40% of new SNF Admissions were Attributed in 2013 LTPAC Medical Group study
  - POS 13/33 – Adult-Home/Assisted-Living Both Considered as Primary Care

MIPS (2017 -)

- Patient Attribution Based on plurality of care
  - *Based on Primary Care Encounters (if present)*
  - POS 31(SNF) no longer Primary Care – now
  - POS 32 (NF) Remains as Primary Care
  - POS 13/33 – Adult-Home/Assisted-Living Both Considered as Primary Care

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MIPS Component: Resource Use

Replaces Cost Component of Value-based Payment

Summary:

- CMS calculates based on claims so there are no reporting requirements for clinicians ; you are subject to any measure based upon claims data

Changes from VBP:

- Moved: Costs for 4 episode-specific measures
  - Congestive Heart Failure (CHF)
  - Coronary artery disease (CAD)
  - Chronic obstructive pulmonary disease (COPD)
  - Diabetes mellitus (DM)
- Added: MIPS will contain 41 episode specific measures to related to Specialists’ Hospital Care

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MIPS Component: Resource Use

10% of Composite Score

Measure	Possible Points	Score
~~Medicare Spending Per Beneficiary (MSPB)~~	~~10~~	
~~Episode- Based Measures~~	~~Varies~~	
Total Per Capita Cost	10	2

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MIPS Components: Quality Deep Dive

50%

Quality

10%

Resource Use

15%

Clinical Practice Improvement Activities

25%

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MIPS Component: Clinical Practice Improvement Activities

15% of Composite Score

Clinical Practice Improvement Activities			
	Relative Weight (High 20, Medium 10)	**Points Received**	**% of Total**
Activity 1	High	20	
Activity 2	Medium	10	
Activity 3	Medium	10	
Activity 4	Medium	10	
Activity 5	Medium	10	
Total Points	**60 Point Maximum**	**60**	100%
CPIA Contribution to MIPS			15%

- 90+ Possible Activities
- Choose Between 3 -6 Activities
  - High Value Activities = 20 Points
  - Medium Value Activities = 10 Points

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CPIA: Executing the Strategy
Activities to Consider

Clinical Practice Improvement Activities		
Activity	**Relative Weight (High 20, Medium 10)**	**Points**
Systematic Anticoagulation Program ★	High	20
Timely Communication of Test Results ★	Medium	10
Implementation of Regular Care Coordination Training	Medium	10
Patient and Family Engagement	Medium	10
Decision Support & Protocols to Manage Workflows	Medium	10
See New & Follow-Up Medicaid Patients ★	High	20
Diabetes Screenings for Patients w/ Schizophrenia or Bipolar Disease who are using Antipsychotic Medications ★	Medium	10

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MIPS Component: Clinical Practice Improvement Activities
Reporting

Forms of Data Submission

- 2017 Attestation Only Via:
  - Qualified Clinical Data Registry QCDR
  - EHR
  - Claims
  - CMS Web Interface
  - Expect further instructions on data submission and activity details in the Final Rule

- May attest individually or as a group.

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CPIA: Executing the Strategy
Special Considerations

- Special Considerations
  - Attest as group of less than 15 Clinicians
    - Receive 50% credit for the first activity; second activity fulfills the 100%.
    - Activity weights can be high, medium, or both
  - Members of PCMH receive full credit for the CPIA component automatically
  - Members participating in an Alternative Payment Model (APM) automatically receive half credit
  - No Hardship Exemptions

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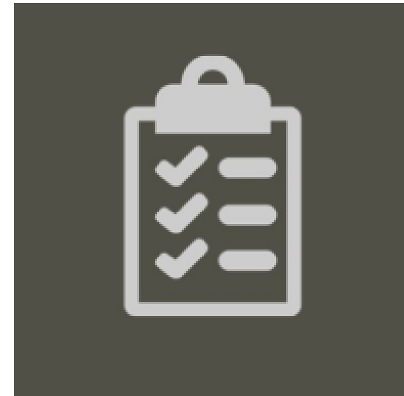
MIPS Components: Quality Deep Dive

50%

Quality

10%

Resource Use



15%

Clinical Practice Improvement Activities

25%

Advancing Care Information

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Component: Advancing Care Information (ACI)

Replaces Meaningful Use

Meaningful Use	Advancing Care Information (ACI)
Reports on all objectives & measure requirements	Emphasizes interoperability, information exchange, and security measures. Clinical Decision Support & CPOE are no longer required
One-Size Fits All: every measure reported & weighed equally	Customizable: Clinicians choose which measure best fit their practice
All-or-Nothing EHR measurement & quality reporting	Flexible: Multiple paths to success
Misaligned with other Medicare reporting programs	Aligned with other Medicare reporting programs - No need to report quality measures as part of this category

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Base Score: Six Objectives
Accounts for 50 Points of Total ACI Score

Protect Patient Health Information
(Yes, Required)

Electronic Prescribing
(Numerator/Denominator)

Patient Electronic Access
(Numerator/Denominator)

Coordination of Care Through Patient Engagement
(Numerator/Denominator)

Health Information Exchange
(Numerator/Denominator)

Public Health & Clinical Data Registry Reporting
(Yes, Required)

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Performance Score
Accounts for 80 Points of Total ACI Score

Patient Electronic Access (Numerator/Denominator)

Coordination of Care Through Patient Engagement (Numerator/Denominator)

Health Information Exchange (Numerator/Denominator)

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Advancing Care Information (ACI) – Scoring

Objective	Measure for MIPS (2017 only)	Base Score	Performance Score	Performance Score Possible Points	Score
1. Protect Patient Heath Information	Security Risk Analysis	0 or 50			
2. Electronic Prescribing	ePrescribing				
	Drug Formulary				
3. Clinical Decision Support (CDS)*	Clinical decision Support (CDS) Intervention				
	Drug-Drug and Drug Allergy Interactions				
4. Computerized Provider Order Entry (CPOE) *	Medication Orders				
	Laboratory Orders				
	Diagnostic Imaging Orders				
5. Health Information Exchange	Patient Care Record Exchange				
6. Medication Reconciliation	Medication Reconciliation				
7. Public Health Reporting	Public Health Reporting				
	Specialized Registry Reporting				
8. Patient Electronic Access	Patient Access			10	
	View, Download, or Transmit (VDT)			10	
9. Patient-Specific Education	Patient-Specific Education			10	
10. Secure Messaging	Secure Messaging			10	
Total Points		**50**		**40**	
Weighted Score					

Advancing Care Information (ACI) – Scoring

Objective	Measure for MIPS (2017 only)	Base Score	Performance Score	Performance Score Possible Points	Score
1. Protect Patient Heath Information	Security Risk Analysis	0 or 50			
2. Electronic Prescribing	ePrescribing				
	Drug Formulary				
3. Clinical Decision Support (CDS)*	Clinical decision Support (CDS) Intervention				
	Drug-Drug and Drug Allergy Interactions				
4. Computerized Provider Order Entry (CPOE) *	Medication Orders				
	Laboratory Orders				
	Diagnostic Imaging Orders				
5. Health Information Exchange	Patient Care Record Exchange				
6. Medication Reconciliation	Medication Reconciliation				
7. Public Health Reporting	Public Health Reporting				
	Specialized Registry Reporting				
8. Patient Electronic Access	Patient Access		10	10	
	View, Download, or Transmit (VDT)		1	10	
9. Patient-Specific Education	Patient-Specific Education		5	10	
10. Secure Messaging	Secure Messaging		10	10	
Total Points		**50**	**26**	**40**	**76**
Weighted Score		**12.5**	**6.5**	**NA**	**19**

MIPS Score Card

Quality

Measure	Max value	Bonus Points	Data Capture via CHERT?	Score
Diabetes: Hemoglobin A1c Poor Control	10	2	1	5+3
Care Plan	10	1	1	9+2
Influenza Immunization	10		1	9+1
Falls: Risk Assessment	10	1	1	10+2
Adult Sinusitis: Appropriate Choice of Antibiotic:	10		1	4+1
Body Mass Index (BMI) Screening and Follow-Up Plan	10		1	8+1
CMS-1 –Acute Conditions Composite	10			2
CMS-2 – Chronic Conditions Composite	10			5
CMS-3 – All Cause Rehospitalizations	10			6
Total Points	**90**			**68**
Weighted Score	**50%**		**(68/90)x 50%**	**38%**

Clinical Practice Improvement Activities

Activity	Possible Points	Score
Systematic Anticoagulation Program	20	20
Timely Communication of Test Results	10	10
See New & Follow-Up Medicaid Patients	20	20
Diabetes Screenings for Patients w/ Schizophrenia or Bipolar Disease	10	10
Total Points	**60**	**60**
Weighted Score		**15%**

Resource Use

Measure	Possible Points	Score
#1 – MSPB	N/A	N/A
#2- 41 Episode Costs	N/A	N/A
#3 Total Per Capita Cost	10	2
Total Points	**10**	**2**
Weighted Score	**(2/10)x10%**	**2%**

Advancing Care Information

Measure for MIPS (2017 only)	Possible Points	Score
Security Risk Analysis	1/yes	0 or 50
ePrescribing	1/yes	
Clinical decision Support (CDS) Intervention	1/yes	
Drug Interaction & Drug Allergy Checks Medication Orders	1/yes	
Laboratory Orders	1/yes	
Diagnostic Imaging Orders	1/yes	
Patient Care Record Exchange	1/yes	
Medication Reconciliation	1/yes	
Public Health Reporting	1/yes	
Specialized Registry Reporting	1/yes	
		50
Patient Access	10	10
View, Download, or Transmit (VDT)	10	5
Patient-Specific Education	10	1
Secure Messaging	10	10
Total Points	**100**	**76**
Weighted Score	**(76/100)x 25%**	**19%**

Easy-Read MIPS Score Card

PASS

MIPS Category	Points Possible	My Score	% of Composite Score	Our Score
Quality	90	68	50%	38
Clinical Practice Improvement Activities	60	60	15%	15
Resource Use	10	2	10%	2
Advancing Care Information	100	76	25%	19
Total			100%	74

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CMS announcement-September 8, 2016

- First Option: Test the Quality Payment Program
  - Clinicians must submit some QPP data, including data from after January 1, 2017, to avoid a negative payment adjustment. This first option is designed to ensure that their systems are working and that they are prepared for broader participation in 2018 and 2019. The assumption under this option (although not explicit) in the information announced thus far, is that clinicians choosing this track would not be eligible for positive payment adjustments in 2019.

- Second Option: Participate for part of the calendar year
  - Clinicians can choose to submit QPP information for a reduced number of days in 2017, which allows their first performance period to begin after January 1, 2017. Under this option, clinicians could still qualify for a small positive payment adjustment in 2019.

- Third Option: Participate for the full calendar year.
  - Clinicians that are ready to move forward on January 1, 2017, can choose to submit QPP information for a full calendar year, and their first performance period would begin on January 1. This option would allow these clinicians to qualify for a modest positive payment adjustment.

- Fourth Option: Participate in an Advanced Alternative Payment Model in 2017

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Glossary of Terms

- ACI - Advancing Care Information, formerly known as Meaningful Use
- CPIA - Clinical Practice Improvement Activities
- MIPS - MIPS composite performance score
- EC - Eligible Clinician, the new definition of professionals who fall under this category under MACRA
- MIPS - Merit Based Incentive Payment System, the combination of MU, PQRS, VM and new CPIA
- QPP - Quality Payment Program, the overarching name that covers MIPS and APM tracks

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Questions?

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Coffee Break

Presentations will resume at 3:15pm

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MIPS Strategy: Scorecard, QRUR Review, and Q&A

Rod Baird, President
Jenny Liljeberg, Regulatory Affairs Manager
Mikell J. Clayton, Regulatory Compliance Specialist

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Successful Strategies for MIPS Success-Pick Your Pace

- Option 1: Test The QPP
- Option 2: Participate for part of the calendar year
- Option 3: Participate for the full calendar year
- Option 4: Participate in an Advanced Alternative Payment Model in 2017.

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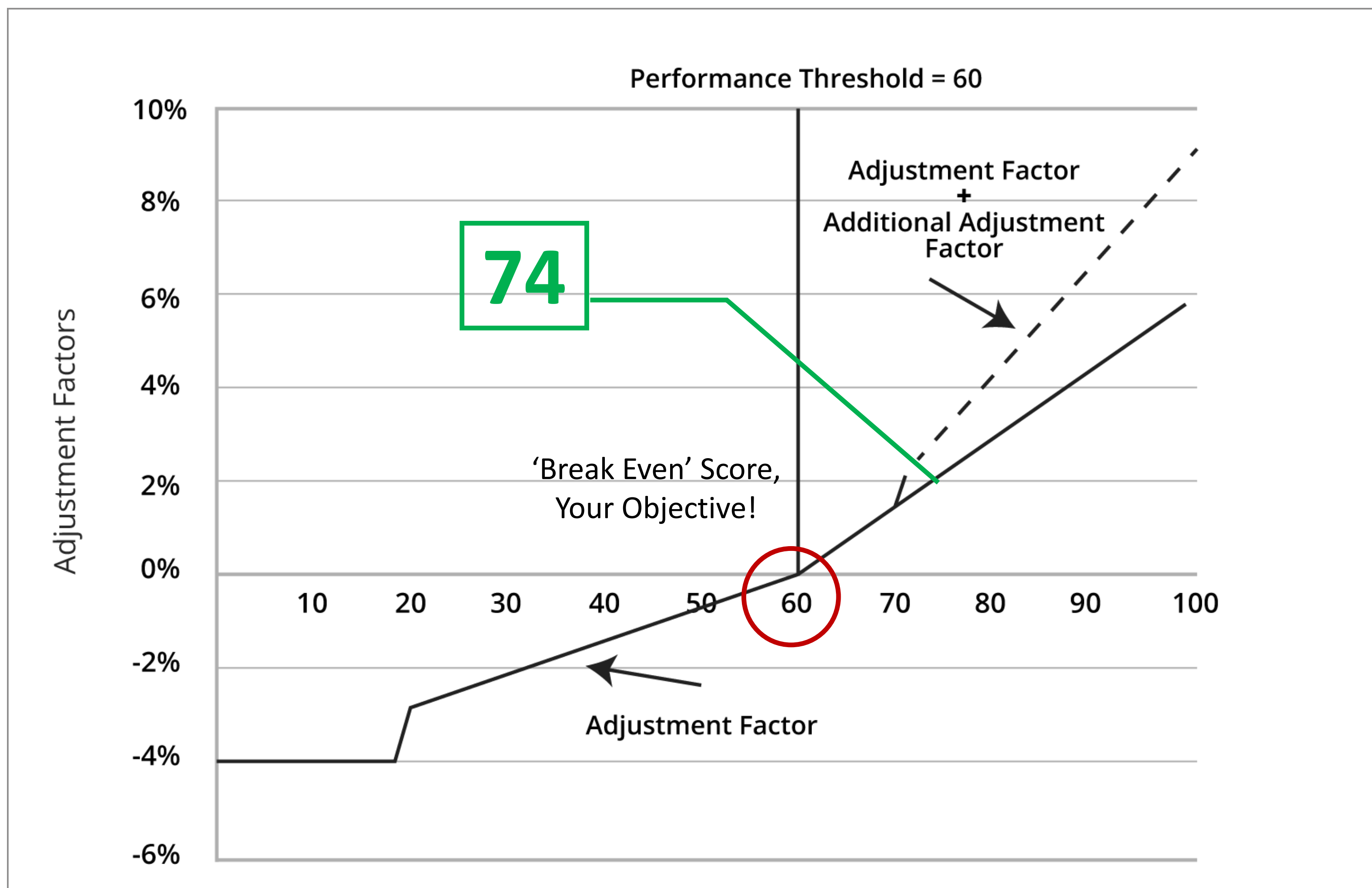
MIPS Adjustment Factors Based on Composite Performance Scores



- Score below 'Break Even' point (60), pay a penalty
- Score above 'Break Even' point (60), earn incentive money
- Below the 'Break Even' Point (Penalized)
    - ¼ of the bottom half (1/8 of total players), receive flat 4% penalty.
    - The rest have a gradually decreasing penalty until the 'break even' point.
- Above the 'Break Even' Point (Rewarded)
    - Gain incentive bonus linearly

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Question One – Do You Even Care?

Below the ‘Break Even’ Point (Penalized)

- ¼ of the bottom half (1/8 of total players), receive flat 4% penalty.
- The rest have a gradually decreasing penalty until the ‘break even’ point.

Above the ‘Break Even’ Point (Rewarded)

- Gain incentive bonus linearly

Depending on the Final Rule- this maybe easier to achieve

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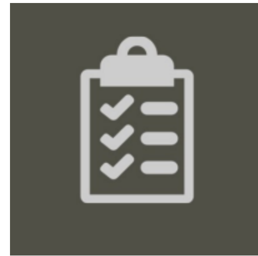
LTPAC Strategic Option #1

1. Request an EHR Hardship



50%	~~10%~~ 20%	~~15%~~ 30%	~~25%~~
Quality	Resource Use	CPIA	~~ACI~~

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Easy-Read MIPS Score Card

Reweighting of ACI

MIPS Category	Points Possible	My Score	% of Composite Score	Our Score
Quality	90	68	50%	38
Clinical Practice Improvement Activities	60	60	30%	30
Resource Use	10	2	20%	4
Advancing Care Information	N/A	N/A	0%	N/A
Total			100%	72

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LTPAC Strategic Option #1

≤ 15 Members

(Represents 90% of all LTPAC Medical groups.)

- Limited infrastructure
- Challenged to finance expanded staff
- Clinical Practice Improvement: **Only Two Activities Required**

> 16 Members

(~ 50% of LTPAC Clinical Workforce)

- Estimate these represent over 50% of the LTPAC Clinical Workforce
- More management infrastructure
- Likely aware of population management movement
- More sophisticated billing and compliance

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Strategies - Large Group Practices > 15

- Attempt ACI - but file for a hardship
- Choose 3 high-weighted Clinical Practice Improvement Activities (CPIA) for full credit
- Attest as a group: divide and conquer!
- Align other programs to satisfy some MIPS requirements, such as CCM services that align with Clinical Practice Improvement Activities.

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Strategies - Large Group Practices > 16

Large Groups Should Consider Allied Health Professionals

- We see definite trend to employing RN/LPN or Certified Medical Assistants in larger practices.
  - Help with data gathering in the field
  - Support Meaningful Use
  - Work as Practitioners' liaison with buildings' clinical staff
- Licensed Healthcare Professionals can help with executing a Chronic Care Management (CCM) strategy – a reimbursable Part B service in POS 32

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Chronic Care Management (CCM)– CPT® 99490

- CCM is a CPT® Code which pays Physicians (and NPs?) a monthly fee of ~$43 per patient if:
  - Patient Enrolls in CCM with the Physician
  - Clinical Staff supervised by the Physician, document 20+ minutes of care management in an EHR during the month.
  - A large number of defined performance criteria are satisfied (e.g. formal care plan, electronic Transitions of Care, etc.)
- The Draft 2017 MCR PFS is proposing to simplify many of the technical requirements to improve CCM use by Physicians

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Quality and Resource Use Reports (QRUR) Review

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What is a QRUR?

- The Quality Resource and Use Report (QRUR) shows how your payments under Medicare Part B fee-for-service (FFS) will be adjusted based on quality and cost.
- CMS provides QRURs as a means to help physicians and groups understand the care they deliver to Medicare beneficiaries and identify opportunities for improvement in that care.
- QRURs are provided for each Medicare-enrolled Taxpayer Identification Number (TIN)

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How to Access my QRUR

- QRURs are available at the TIN level and accessed via the CMS Enterprise Portal(portal.cms.gov) by authorized individuals of solo or group practices. Each TIN needs a designated "security official," or in the case of solo practices, an "individual practitioner." This role is acquired through the CMS Enterprise Identity Management (EIDM) system.

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How Are Patient's Attributed to Me?

- CMS attributes patients by a two-step attribution process.
  - Step 1: A beneficiary is attributed to a TIN if the TIN's primary care physicians (PCPs)— defined as family practice, internal medicine, geriatric medicine, or general practice physicians— accounted for a larger share of allowed charges for primary care services for the beneficiary than PCPs of any other TIN.
- Step 2: Beneficiaries who are not assigned to a TIN after the first step may be assigned to the TIN whose Step 2 Professionals [i.e., physician specialists, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs)] accounted for more Medicare allowed charges for primary care services than any other TIN. 5

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Who Is Excluded from Attribution?

- Beneficiaries enrolled in Medicare Part A only or Medicare Part B only for any month during the year

- Beneficiaries enrolled in Medicare managed care

- Beneficiaries who resided outside the US, its territories, for any month during the year

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The Flaws in Methodology

- LTPAC patients tend to be high-cost consuming patients that require high needs.
- These patients who have multiple complex medical conditions account for a disproportionately higher share of healthcare spending.
- Providers who serve only LTPAC patients have their patient’s cost and quality compared to providers who work primarily in ambulatory care settings.

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Risk Adjustment – Hierarchical Condition Categories (HCC)

- The basic premise of HCC Risk adjustment is using a patient's diagnosis and demographics to predict medical expenditure risk.

- In the absence of risk adjustment, TINs treating a large number of beneficiaries with multiple chronic conditions could perform worse on certain quality and cost measures than TINs with relatively healthy beneficiaries due, at least in part, to differences in their beneficiary populations. Risk adjustment facilitates more accurate comparisons by accounting for differences in beneficiary case mix across TINs

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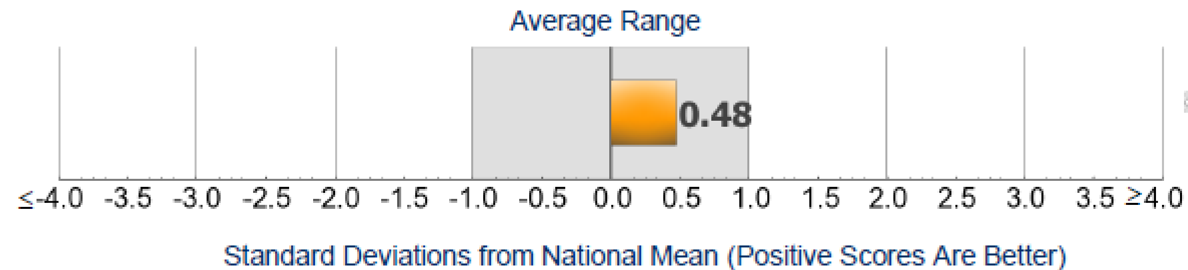
Sample QRUR Performance Score

PERFORMANCE HIGHLIGHTS

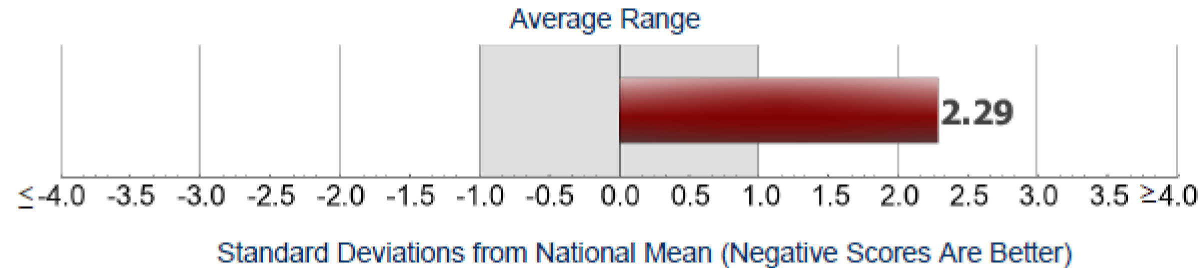
Your TIN's Quality Composite Score: Average

The graph below displays your TIN's standardized Quality Composite Score.



Your TIN's Cost Composite Score: High

The graph below displays your TIN's standardized Cost Composite Score.



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CMS-Mandated Outcome Measures

Exhibit 6-CCC-B. Communication and Care Coordination Domain Quality Indicator Performance (CMS-Calculated Outcome Measures)

Performance Category	Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score?
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions	CMS-1	Acute Conditions Composite	3,034	19.77	7.53	1.81	13.24	-2.14	Yes
	-	Bacterial Pneumonia	3,034	29.59	11.20	1.76	20.63	—	No
		Urinary Tract Infection	3,034	22.20	7.25	0.00	15.08	—	No
		Dehydration	3,034	7.16	4.10	0.00	8.58	—	No
	CMS-2	Chronic Conditions Composite	2,073	57.38	50.43	26.19	74.66	-0.29	Yes
	-	Diabetes (composite of 4 indicators)	1,125	59.97	18.07	0.00	38.07	—	No
		Chronic Obstructive Pulmonary Disease (COPD) or Asthma	952	54.46	70.23	25.43	115.03	—	No
		Heart Failure	1,301	99.96	99.75	48.72	150.77	—	No
Hospital Readmissions	CMS-3	All-Cause Hospital Readmissions	2,098	16.09%	15.94%	14.55%	17.34%	-0.10	Yes

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Per Capita Cost

Exhibit 10. Per Capita or Per Episode Costs for Your TIN's Attributed Medicare Beneficiaries

Cost Domain	Cost Measure	Your TIN's Eligible Cases or Episodes	Your TIN's Per Capita or Per Episode Costs	Benchmark	Benchmark – 1 Standard Deviation	Benchmark + 1 Standard Deviation	Standardized Score	Included in Domain Score?
Per Capita Costs for All Attributed Beneficiaries	Per Capita Costs for All Attributed Beneficiaries	2,208	$23,905	$10,907	$8,066	$13,749	4.57	Yes
	Medicare Spending per Beneficiary	21	$24,261	$20,475	$18,877	$22,073	2.37	Yes
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes	816	$31,044	$15,826	$11,466	$20,185	3.49	Yes
	Chronic Obstructive Pulmonary Disease (COPD)	636	$44,505	$24,854	$17,524	$32,185	2.68	Yes
	Coronary Artery Disease (CAD)	895	$35,430	$18,234	$13,132	$23,336	3.37	Yes
	Heart Failure	863	$46,944	$28,033	$19,606	$36,460	2.24	Yes

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Resource Use- 2017 and Beyond
Replaces Cost Component of Value-based Payment

Summary:

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Changes from VBP:

- **Moved:** Costs for 4 episode-specific measures
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  - Coronary artery disease (CAD)
  - Chronic obstructive pulmonary disease (COPD)
  - Diabetes mellitus (DM)
- **Added:** MIPS will contain 41 episode specific measures to related to Specialists' Hospital Care

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VBP (2012 -2016)

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  - *Based on Primary Care Encounters (if present)*
  - POS 31 and 32 Both Considered as Primary Care
  - Nearly 40% of new SNF Admissions were Attributed in 2013 LTPAC Medical Group study
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MIPS (2017 -)

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MIPS Component: Resource Use

10% of Composite Score

Measure	Possible Points	Score
~~Medicare Spending Per Beneficiary (MSPB)~~	~~10~~	
~~Episode- Based Measures~~	~~Varies~~	
Total Per Capita Cost	10	

- How will your Medicare spending compares to your peers like-minded professionals
- Reduce consumption of Medicare benefits
- You will be assessed based upon peer group benchmarking
  - 2017 same as value-based purchasing

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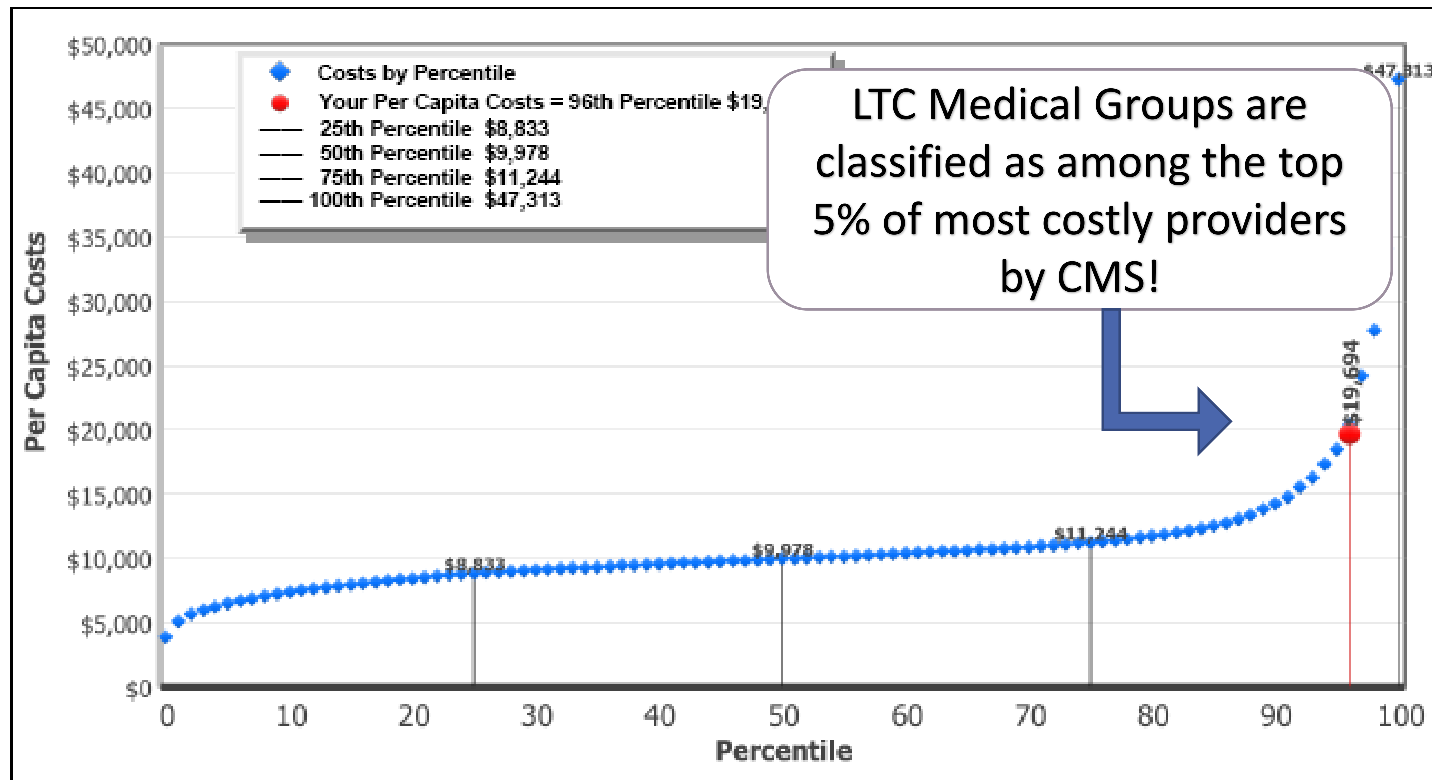
Typical LTPAC Group's Per Capita Cost - VBP



Note: Per capita costs are risk adjusted and payment standardized and are based on payments for Medicare Part A and Part B claims submitted in 2012 by all providers (including medical professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to a medical group practice. Outpatient prescription drug (Part D) costs are not included.

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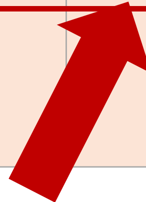
2014 QRUR – Typical LTPAC Cost Performance

Cost Domain	Cost Measure	Your TIN'S Eligible Cases or Episodes	Your TIN's Per Capita or Per Episode Costs	Benchmark	Benchmark - 1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included in Domain Score?
Per Capita Costs for All Attributed Beneficiaries	Per Capita Costs for All Attributed Beneficiaries	2,208	$23,905	$10,907	$8,066	$13,749	4.57	Yes
	Medicare Spending per Beneficiaries	21	$24,261	$20,475	$18,877	$22,073	2.37	Yes



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Hospitalizations and SNF Care Increase LTPAC Cost Scores Into the Top 5% of All Medical Groups.

Service Category	Amount by Which Your TIN's Costs were Higher/(Lower) than Benchmark: Per Capita Costs for all Attributed Beneficiaries
Evaluation & Management Services Billed by Eligible Professionals in **Your** TIN	$83
Evaluation & Management Services Billed by Eligible Professionals in **Other** TINs	($129)
Major Procedures Billed by Eligible Professionals in **Your** TIN	($20)
Major Procedures Billed by Eligible Professionals in **Other** TINs	($89)
Ambulatory/Minor Procedures Billed by Eligible Professionals in **Your** TIN	($59)
Ambulatory/Minor PRocedures Billed by Eligible Professionals in **Others** TINs	($181)
Ancillary Services	($559)
Hospital Inpatient Services	$3,354
Emergency Services Not Included in a Hospital Admission	$181
Post-Acute Services	**$10,454**
Hospice	$825
All Other Services	($864)

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What Are Your Options?

Shedding POS 31 for RU Attribution (Costs Prior to Risk Adjustment)

	Admission Year			
Attributed?	Before 2013	2013	**Total**	**%**
Yes	1940	1252	3192	53%
No	805	2063	2868	47%
Total	2745	3315	6061	100%

Attributed?	**Before 2013**	**2013**	**Total**
Yes	1940	1252	3192
%	61%	39%	100%

Admission Year	**Before 2013 = POS 32**		**2013 = POS 31**	
Hospitalization during 2013?	No	Yes	No	Yes
Standardized FFS Medicare Cost	$9,062	$56,013	$14,095	$67,068
Average HCC Percentile	80	84	63	66
% of Attributed Patient Census	44%	16%	9%	31%
Average Cost	$21,752		$54,750	

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Risk Adjustment – Can Further Lower Per Capita Costs

Based on Diagnoses from Prior Year's Paid Claims

Cost Categories	Per Capita Costs Before Risk Adjustment	Per Capita Costs After Risk Adjustment
Per Capita Costs for All Attributed Beneficiaries		
All Beneficiaries	$34,928	$20,297

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Can you improve your QRUR Scores?

LTPAC Resource Use Score Is not controllable

- A Financial problem for Physician Led Groups in 2017
- A Policy Problem in 2018 and beyond
- LTPAC MD/DO? -You will have a <2%> payment adjustment for 2017

Quality Measurement is partially managable

- Must report PQRS to avoid 1st <2%> penalty
- 2016 Quality Scores > -1 you avoid added <2%> adjustment
- *A 2016 Score > 1.0 will wipe out the Resource Use Payment Adjustment –*

IS THIS POSSIBLE????

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Recapping a 2015 Users Group Presentation

- Proposed experiment to improve QRUR Quality Score
  - Meet PQRS reporting via use of Measures Groups – simple for average clinician
  - Pick selected Individual Measures to offset bad scores for high hospitalization rates
  - Train selected clinicians to work on those very specific Measures
  - Manage your Registry Submissions to report on your best performers (those who are OCD about fully documenting care)

The Results are IN

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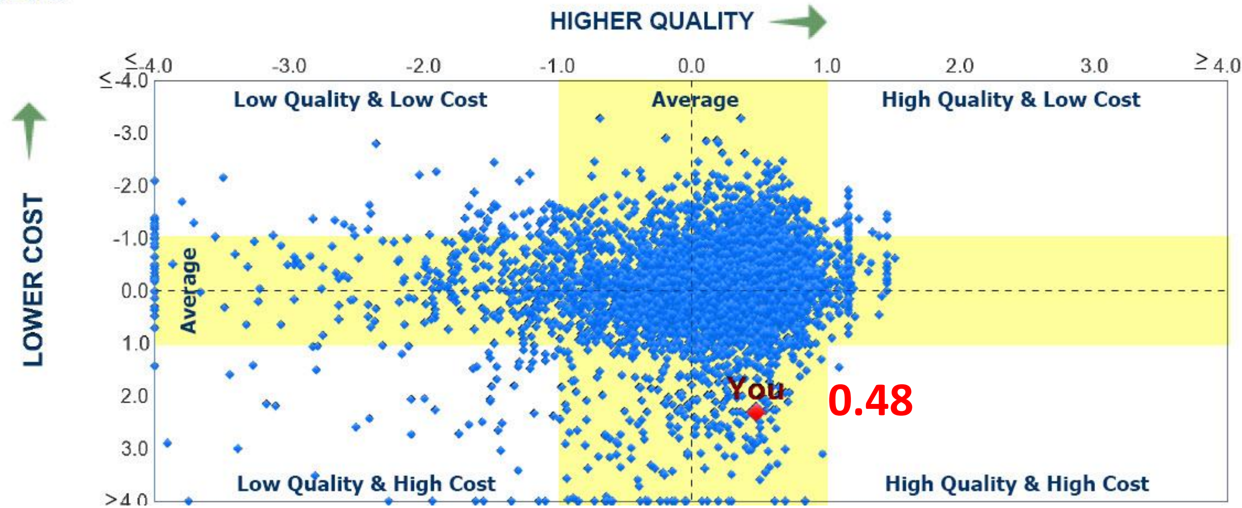
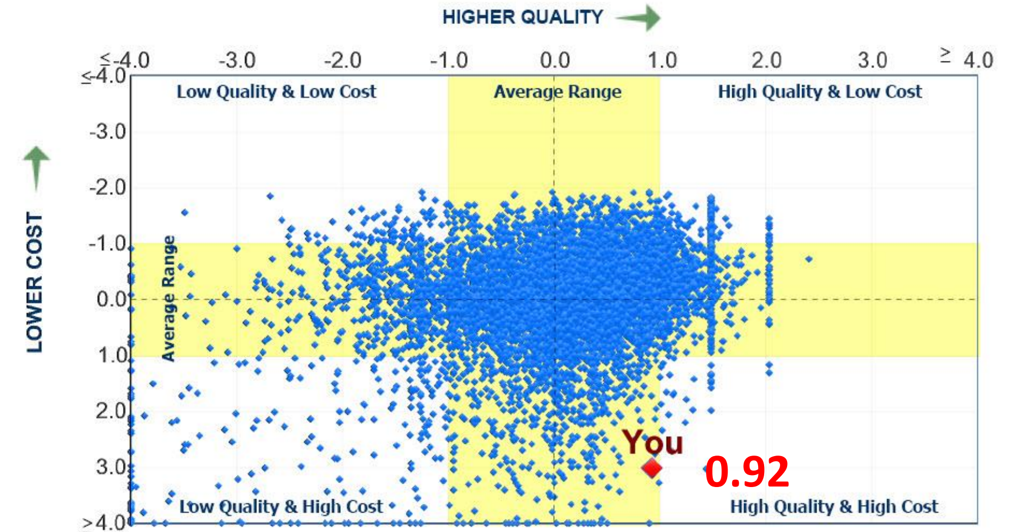
2014 QM vs 2015





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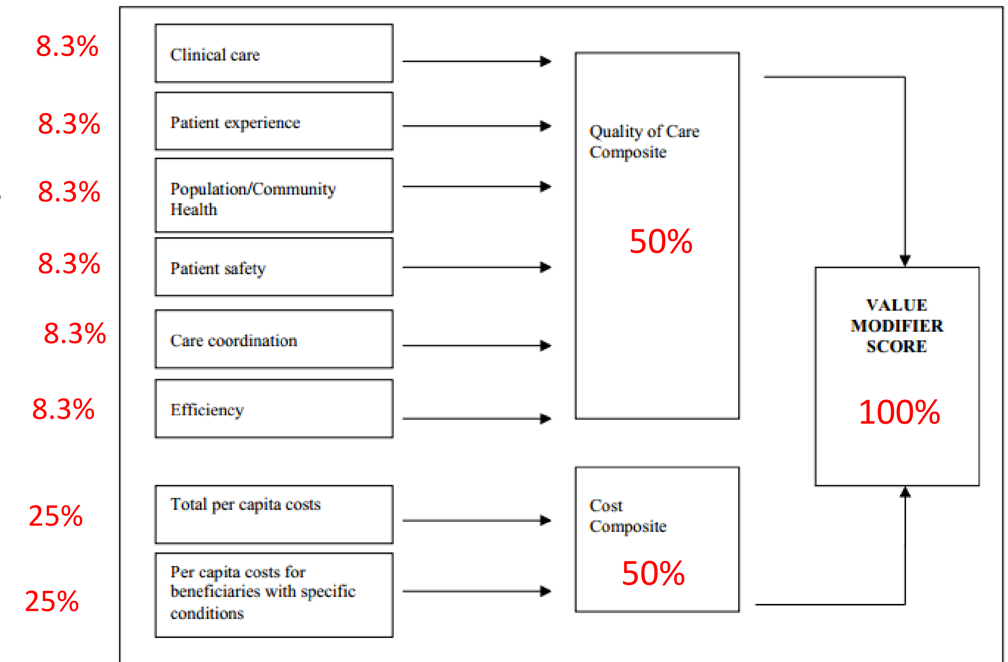
What is the Quality of Care Composite?

- Successfully reporting PQRS adds measures to quality composite domains.
- For PQRS measure to be included in a domain, 50% of the eligible patients per provider must have that measure scored (50% threshold) for individual measures or 20 cases must be scored for measures groups (at least 11 of which are for Medicare patients).
- All measures are equally weighted in each domain.
- Measures scores are compared to the benchmark from the previous year to get standardized performance scores for each domain.



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Each Domain Score is an Average of the Standardized Quality Measures

Quality measure	Individual Group Performance Score	Benchmark (National Mean)	Individual Group Score Minus Benchmark	Standard Deviation	Standardized Score (Diff/St Dev)
Measure 1	95.0%	93.5%	1.5	3.3%	+0.47
Measure 2	71.4%	86.3%	-14.9	13.9%	-1.07
Measure 3	100.0%	60.6%	39.4	13.2%	+2.98
Domain Score (average std score)					**0.79**

Graphic from
http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/GIM/education/ContinuingEducation/Documents/GPRO%20Presentation%20GIM%20Grand%20Rounds%20081313.pdf

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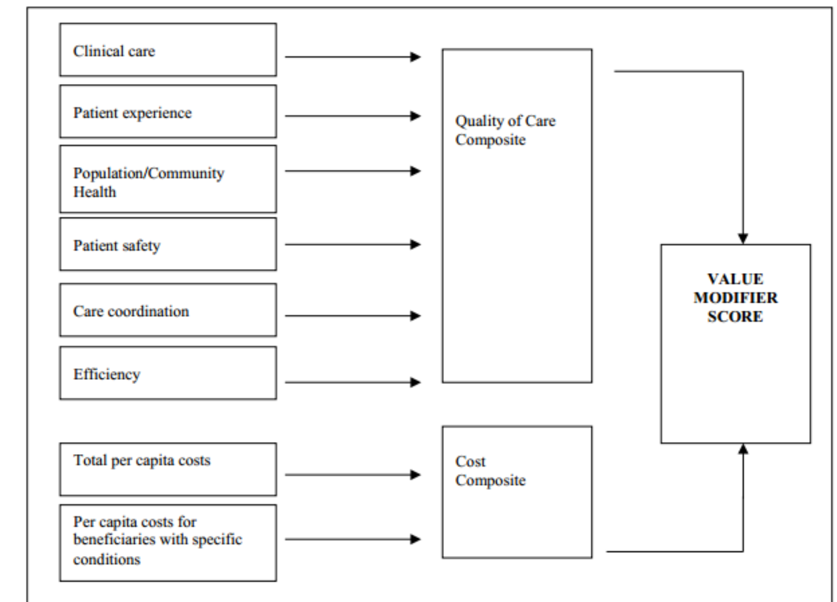
Domains are then Averaged Equally to Produce the Quality Composite Score

- This Quality of Care Composite Score is then compared to a national mean.
- Where that score falls in relation to the mean (more than 1 standard deviation) indicates the percentage of the quality penalty or incentive (if average, 2% VM penalty (due to high cost)).

Exhibit 5. Your TIN's Performance in 2014, by Quality Domain

Quality Domain	Number of Quality Measures Included in Composite Score	Standardized Performance Score (Quality Tier Designation)
Quality Composite Score	**10**	**0.48 (Average)**
Effective Clinical Care	3	0.44
Person and Caregiver-Centered Experience and Outcomes	0	—
Community/Population Health	2	1.40
Patient Safety	1	0.23
Communication and Care Coordination	4	-0.29
Efficiency and Cost Reduction	0	—



(0.44 + 1.40 + 0.23 -0.29)/4 = 0.46

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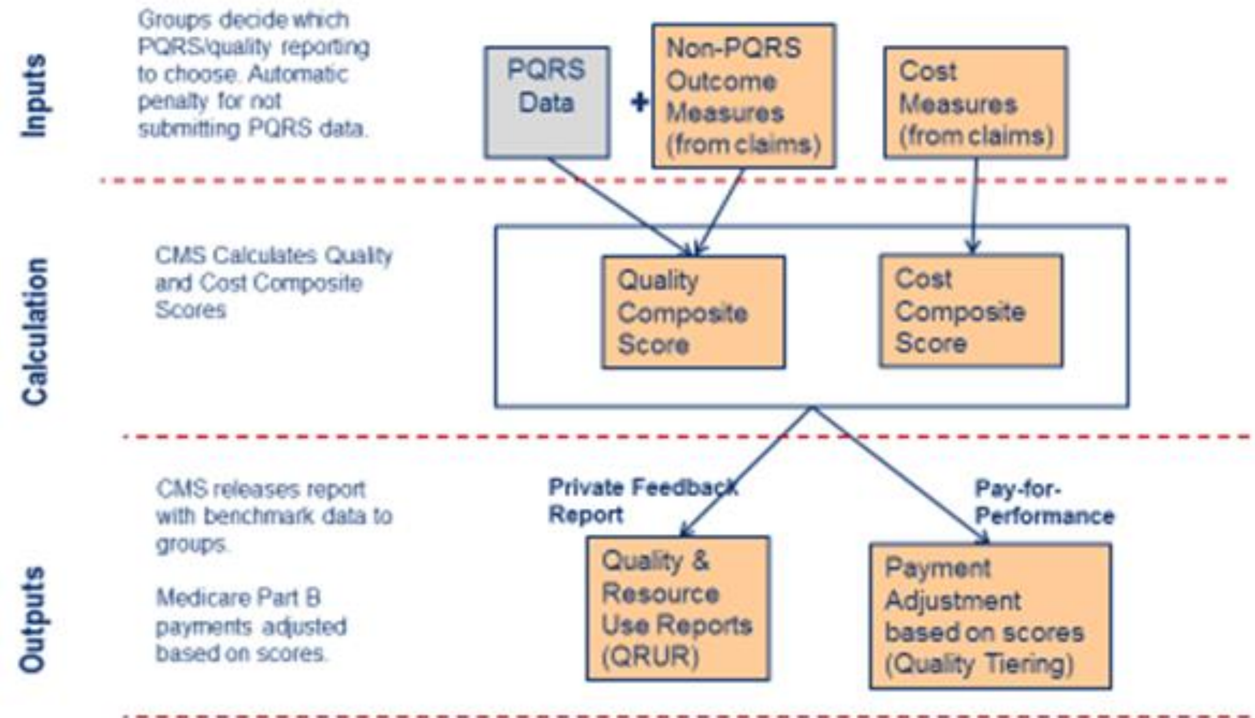
PQRS Measures Contribute to the Quality Score but are Not the Only Factor for Quality

- PQRS measures submitted by a practice are only a part of the Quality Composite Score.
- Non-PQRS Outcome Measures (from claims) are added to the PQRS measures you report. These Outcome Measures from claims populate the Care Coordination Domain.



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MIPS changes the calculus of Quality

- VBP –
- Only 3 Quality Tiers –
  - 10% Low
  - 80% Average
  - 10% High

- MIPS
- **Continuous scoring on a curve**
- Quality is 50% of total Payment Adjust for 2019 based on 2017
- Won't know final rules until November
- Real Change comes from facility/provider/patient level analysis

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Analysis is going to HURT

Supplementary Exhibits 1-4_2014 Annual QRUR Mountains.xlsx - Excel   Rod Baird

File Home Insert Draw Page Layout Formulas Data Review View Tell me what you want to do   Share

C5 fx 8/22/1938

nentary Exhibit 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Quality Outcome Measures, and the Care that You and Others Provided

	Beneficiaries Attributed to Your TIN					Medicare FFS Claims Filed by Your TIN			EP in TIN Billing Most		EP in TIN Billing Most Non-Primary Care				EP Outside of TIN Billing		EP Outside of TIN Billing		Hospital Admission	Chronic Condition Subgroup †			
	DOB	Index †	HCC Percentile Ranking †	Died in 2014	Basis for Attribution †	Date of Last Claim Filed by TIN	Number of Primary Care Services † Provided by TIN	Percent of Primary Care Services † Billed by TIN	Specialty	Date of Last Claim Filed by NPI	NPI	Name	Specialty	Date of Last Claim Filed by NPI	Specialty	Date of Last Claim Filed by NPI	Specialty	Date of Last Claim Filed by NPI	Date of Last Hospital Admission	Diabetes	Coronary Artery Disease	Chronic Obstructive Pulmonary Disease	Heart Failure
4	08/20/1940	1E+08	84	X	Step 1	05/13/2014	3	27.57%	Internal Medicine	04/16/2014	-	NONE	-	-	Nurse Practitioner	04/23/2014	Internal Medicine	05/07/2014	05/06/2014	◆	-	-	◆
3024	10/26/1954	99446720	98	-	Step 1	12/31/2014	12	42.38%	Family Practice	11/21/2014	-	NONE	-	-	Orthopedic Surgery	11/13/2014	Clinical Psychologist	12/03/2014	-	◆	◆	-	◆
3025	04/21/1938	99468061	91	-	Step 1	07/28/2014	7	36.68%	Physician Assistant	07/25/2014	-	NONE	-	-	Family Practice	08/13/2014	Gastroenterology	08/01/2014	07/31/2014	-	-	-	◆
3026	05/05/1938	99484894	71	-	Step 1	11/25/2014	14	81.24%	Internal Medicine	10/14/2014	-	NONE	-	-	Family Practice	05/06/2014	Gastroenterology	10/08/2014	06/16/2014	◆	-	-	-
3027	05/16/1938	99542192	61	-	Step 1	12/30/2014	32	100.00%	Internal Medicine	12/30/2014	-	NONE	-	-	-	-	Nurse Practitioner	11/05/2014	-	-	-	-	-
3028	05/18/1938	99590171	47	-	Step 1	12/20/2014	11	56.08%	Family Practice	10/30/2014	-	NONE	-	-	Family Practice	04/21/2014	General Surgery	04/27/2014	11/14/2014	◆	-	-	-
3029	02/14/1938	99616887	83	-	Step 1	12/17/2014	12	75.78%	Nurse Practitioner	09/23/2014	1891732491	JAN ALLISON	Nurse Practitioner	########	Cardiology	04/09/2014	Clinical Psychologist	09/15/2014	-	◆	◆	-	-
3030	06/01/1938	99618010	56	-	Step 1	12/29/2014	2	100.00%	Internal Medicine	12/29/2014	-	NONE	-	-	-	-	Internal Medicine	12/15/2014	12/10/2014	◆	◆	◆	-
3031	04/13/1944	99698013	88	-	Step 1	12/08/2014	16	100.00%	Internal Medicine	12/08/2014	-	NONE	-	-	-	-	Optometrist	08/11/2014	-	◆	-	-	◆
3032	04/25/1956	99769699	83	-	Step 1	12/01/2014	14	100.00%	Internal Medicine	12/01/2014	-	NONE	-	-	-	-	Nurse Practitioner	12/24/2014	-	-	-	-	-
3033	07/02/1938	99856356	37	X	Step 1	03/27/2014	1	37.73%	Internal Medicine	03/27/2014	-	NONE	-	-	Internal Medicine	03/03/2014	Internal Medicine	03/24/2014	03/13/2014	-	◆	-	-
3034	04/02/1941	99873066	86	-	Step 1	06/02/2014	5	38.17%	Internal Medicine	06/02/2014	-	NONE	-	-	Rheumatology	12/09/2014	Orthopedic Surgery	07/21/2014	03/03/2014	-	-	◆	-
3035	07/12/1938	99953821	47	-	Step 1	11/14/2014	4	66.76%	Family Practice	11/14/2014	-	NONE	-	-	Otolaryngology	04/11/2014	Ophthalmology	09/11/2014	-	-	◆	-	-
	01/26/1938	99970988	84						Internal						Physician		Clinical						

Supplementary Exhibit 1 | Supplementary Exhibit 2A | Supplementary Exhibit 2B | Supplemental Exhibit 3A | Supplemental Exhibit 3B | Supplemental Exhibit ...

Ready   Count: 0 Sum: 0 109%

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GPM's Support for MIPS and Beyond

- Creating new standard reports with
  - Annual Census lists
    - Demographics
    - Facility
    - Clinicians
    - Admit/Discharge Dates
    - Level of Care
- Employing Data Scientist for 2017 to experiment with merging gEHRiMed™, CMS, and any available Facility data
  - Goal to create actionable intelligence during the episode to improve risk management

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Why Is this Important?

- Physician Compare includes information about physicians and other health care professionals who satisfactorily participate in CMS quality programs.

- Participation and scores are publicly reported and can be accessed by the general public.

- Resource Use weight increases under MIPS annually.
- Reimbursement is tied to quality and cost consumption.

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How Can GPM Help?

- GPM is actively working on solutions to help practices evaluate QRUR's.

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Questions?

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End of Day One

Thank you for attending!

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