MIPS REPORTING:

WHAT ALL ELIGIBLE CLINICIANS NEED TO KNOW ABOUT THE NEW MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS).

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What is MIPS?

In October 2016, the Department of Health and Human Services (HHS) replaced the Sustainable Growth Rate formula with key provisions of the Medicare Access and CHIP Reauthorization Act of 2015, also known as MACRA. The MACRA final rule was published in October 2016, and was put into effect January 2017.

The MACRA rule reflects the continued efforts by the Department of Health and Human Services (HHS) and the Center for Medicare & Medicaid Services (CMS) to transition the US healthcare system to patient-centric, quality-based care. **MACRA establishes the Quality Payment Program (QPP), which offers two tracks for physicians to receive increases or decreases to their Medicare payments** depending on their reporting of required quality measures: the MIPS and APM (Advanced Payment Model) tracks.

The Merit-Based Incentive Payment System (MIPS) is the track that will apply to most clinicians, and is what we will be discussing in this e-book. **MIPS consolidates performance measures previously required by Meaningful Use (MU), the Physician Quality Reporting System (PQRS), and the Value-Based Modifier (VBM)**, in hopes to achieve one reporting system that is able to measure quality of care provided by all eligible clinicians and group practices, while also holding them accountable for utilizing a certified EHR system in order to advance care information, implementing clinical improvement practices, as well as tracking cost and resource utilization. **The MIPS track is closer to the old fee-for-service model of reimbursement that we have become familiar with, but takes into account both patient volume and the quality of care provided.**

Who is Eligible to Participate?

If you take care of Medicare patients, you are most likely required to participate in MIPS.

2017 and 2018 MIPS-Eligible Clinicians: Physicians (MD/DO and DMD/DDS), Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists

Starting in 2019, MIPS eligibility will be expanded to include Physical and Occupational therapists, Speech-language Pathologists, Audiologists, Nurse Midwives, Clinical Social Workers, Clinical Psychologists, and Dietitians/Nutritional professionals

Both outpatient practice and hospital-based physicians are eligible for MIPS participation, unless they meet the following exclusions:

If you meet any of the below exclusion criteria, you are **not** MIPS-eligible:

- You are newly enrolled in Medicare.
- You see 100 or fewer Medicare Part B patients per year.
- You have less than or equal to $30,000 allowed Medicare Part B charges annually.
- You are on the participant list for a model that CMS has deemed an Advanced Alternative Payment Model (AAPM).

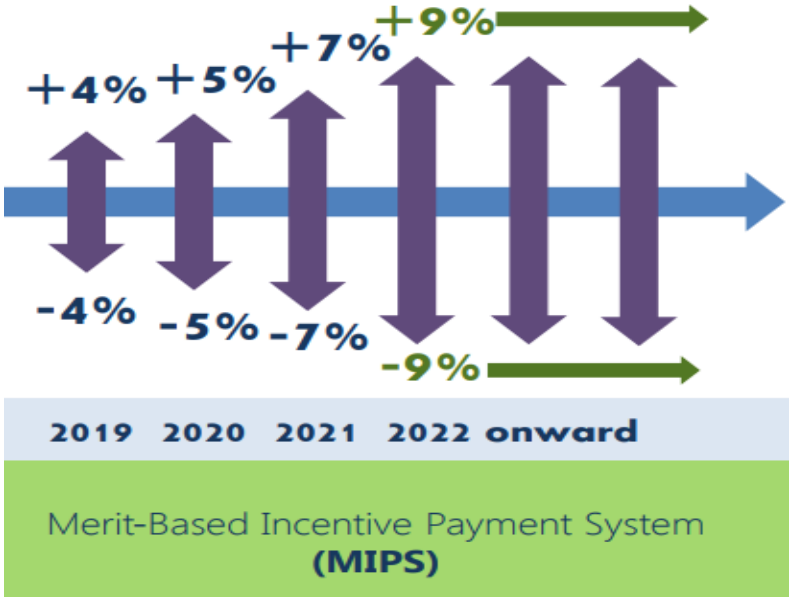
Look up your participation status here with your NPI:

https://qpp.cms.gov/participation-lookup

How will MIPS Impact Clinicians?

CMS predicts that 566,000 Part B clinicians will participate in MIPS. The financial incentives and penalties for MIPS performance scores will continue to grow each year. This program is budget-neutral, as the positive increases to the better performing clinicians are paid by the reimbursement decreases imposed upon the lower-performing clinicians.

However, there is also an additional **$500,000,000 allocated by the QPP to reward the highest-scoring clinicians.** These funds make it possible to earn an **additional 10% increase** in Medicare reimbursement, on top of the yearly payment adjustments.



Reputational Impact

However, payment adjustments are not the only impact that clinicians will feel as a result of MIPS. **Each clinician's MIPS performance score will be displayed** on Medicare's Physician Compare registry (https://www.medicare.gov/physiciancompare), which is easily accessible to patients, other clinicians, insurance payers, and everyone else. In healthcare, more than in any other industry, quality of care and expertise is sought out by its consumers – patients, or their loved ones, at their most vulnerable time. Let your MIPS score speak for you, and serve as your greatest testimonial.

It is important to note that your MIPS score follows you if you move to a different practice/facility. This may prove to be a differentiating factor for employers when hiring new clinicians, as they would be taking on a risk by hiring a clinician with a low MIPS score.

What is being Measured?

- **Quality - 50%:** Clinicians will choose six specialty-specific measures to submit, which show that they are providing quality care to their patients.

- **Advancing care information (ACI) - 25%:** Reflects how clinicians use their EHR systems on a daily basis with continued focus on interoperability and security in information exchange (Meaningful Use).

- **Clinical practice improvement activities (IA) - 15%:** General categories include patient access, care coordination, beneficiary engagement, and patient safety. Clinicians may select specific improvement activities that best fit their organizational goals from a list of more than 90 options. Clinicians also receive credit in this category for participating in APMs or Patient-Centered Medical Home (PCMH) models.

- **Cost (Resource use) - 10%:** Calculated by CMS based on Medicare claims to compare resources used to treat similar care episodes and clinical condition groups across practices. This measure will use more than 40 episode-specific measures to account for differences among specialties.

Remember that in 2017, the Cost category is not included in your final score. **Instead, the Quality Measures category constitutes 60% of your 2017 performance score.**

After 2017, the Cost category will play a factor in your score, but you will not need to report on it – the data will be automatically extracted from your Medicare claims.

2017: Three Participation Tracks

Track	Requirements	Outcome in 2019
Minimum	Report performance on one of the following: • 1 Quality Measure; or • 1 IA (either High or Medium weight); or • 4 or 5 Base Score ACI measures (depends on if you have 2014 or 2015 certified EHR)	Avoid 4% penalty in Medicare reimbursement.
Partial	Report performance for at least 90 days on the following: • More than 1 Quality Measure; or • More than 1 IA; or • Base score ACI measures plus at least 1 additional ACI measure	Avoid 4% penalty and potentially earn a positive payment adjustment.
Full	Report performance for at least 90 days on the following: • 6 Quality Measures, including 1 Outcome measure; and • Combination of High and Medium weight IAs (exact number will vary based on practice size and rural/non-rural location); and • Base score ACI measures plus any additional performance or bonus measures	Avoid 4% penalty and potentially earn a positive payment adjustment.

For participants who have not been actively working on meeting quality measures for at least a 90-day period in 2017, **the Minimum Participation track will be sufficient to avoid a 4% Medicare reimbursement penalty in 2019.**

For participants who can successfully report on the quality measures required for a 90-day period in 2017 must also ensure that they can meet more than one Improvement Activity (IA), as well as the base score Advancing Care Information (ACI measures) – which include a yearly Security Risk Assessment. **Partial Participation will help avoid a 4% penalty in 2019, and may even earn a positive increase in Medicare reimbursement in 2019.**

How to Report?

You can submit MIPS data as an **individual or as a group** under the group practice reporting option (GPRO). If reporting under GPRO, analysis is performed at the Taxpayer Identification Number (TIN) level. The decision to report as an individual or a group must be made by the practice by weighing the pros and cons of each option.

Under GPRO, **all members of the group must use the same measures and penalties or incentives will be applied to the group as a whole.** Keep in mind, if you are a physician who is part of a group, your group **does not have to** report under GPRO— the group still has the option to report as individuals.

Different Ways to Report (Deadline: 03/31/2018):

Qualified Registries - A qualified registry is a CMS-approved entity that collects clinical data from MIPS eligible clinicians (both individual and groups) and submits it to CMS on their behalf for purposes of MIPS.

Qualified Clinical Data Registries (QCDRs) - The QCDR reporting option is different from a qualified registry because it is not limited to measures within the Quality Payment Program.

CMS Web Interface - a secure internet-based data submission option for groups of 25 or more MIPS clinicians reporting quality data to CMS.

EHR - Verify your EHR vendor or registry's capabilities before your chosen reporting period. Contact your EHR vendor or registry directly to verify their reporting deadlines and confirm that they will be able to report your data to CMS. Your EHR vendor may charge you a fee.

Claims-based reporting – this option can be used by individual clinicians only, not by groups. Some MIPS quality measures cannot be reported via claims.

MIPS Beyond 2017

2018, much like 2017, will be considered a transition year during which clinicians will be given more time and leniency to get familiar with the new MIPS requirements before full implementation in 2019. CMS has also made some changes to the 2017 requirements, in order to make the new program more palatable going forward – while also achieving meaningful results.

The performance period for the quality and cost categories is the full year (January 1 - December 31, 2018). Physicians submit quality data and CMS collects cost data from claims. For the ACI and IA categories, the performance period remains a minimum of any continuous 90-day period or longer - up to the full year. MIPS performance data must be submitted by March 31, 2019.

Remember: **If you choose not to participate in 2018, you will receive a negative 5% payment adjustment in 2020. This penalty will gradually increase to negative 9% by 2022.**

There are some notable differences between MIPS in 2017 and MIPS in 2018. CMS hopes to make the process easier and reduce clinicians' burden by making the following amendments for Year 2:

- Excluding individual MIPS eligible clinicians or groups with less than or equal to $90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries.

- Addressing extreme and uncontrollable circumstances, such as hurricanes and other natural disasters, for both the transition year and the 2018 MIPS performance period.

- Including virtual groups as another participation option for year 2.

- Making it easier for clinicians to qualify for incentive payments by participating in Advanced APMs that begin or end in the middle of a year.

MIPS Beyond 2017

Other changes to MIPS in 2018 include:

- Raising the performance threshold to 15 points in Year 2 (from 3 points in 2017) – you must reach a minimum score of 15 points in order to avoid a negative payment adjustment of 5% in 2020.
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2, and giving you a 10 point bonus for using only 2015 CEHRT.
- Giving up to 5 bonus points on your final score for treatment of complex patients.
- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the final score for clinicians impacted by hurricanes Irma, Harvey and Maria and other natural disasters.
- Adding 5 bonus points to the final scores of small practices.
- Adding a new hardship exception for the Advancing Care Information performance category for small practices.

Here are some other ways that clinicians can earn bonus points:

- 10 Bonus for using CEHRT to report one of the specified Improvement Activities.
- 10 points added to performance score for reporting to one or more public health agency or clinical data registry to meet a measure associated with the Public Health and Clinical Data Registry Reporting Objective public.
- Another 5 bonus points to total score for reporting to at least one additional public health agency or clinical data registry that is different from the agency(ies) or registry(ies) applied towards performance score.

Physicians who achieve a final score of 70 or higher will be eligible for an exceptional performance adjustment, funded from a pool of $500 million, applied on a linear scale so that higher scores receive a higher adjustment (from 0.5 to 10 percent).

Frequently Asked Questions

1. I am a hospital-based physician – does MIPS apply to me?

You are considered "hospital-based" if you provided at least 75% of your Medicare professional services in an inpatient hospital, on-campus outpatient, or emergency department setting. A hospital-based physician is subject to all of the same MIPS rules as a physician practicing in other settings except that he or she is not scored on the Advancing Care Information (ACI) category. Instead, hospital-based physician's MIPS score will be based on Quality and Improvement Activities (IA) in 2017. Also in 2017, CMS will use administrative claims data to calculate cost measure results and will report those results to you for informational purposes only.

2. I do not have traditional face-to-face encounters with patients (radiology, pathology and anesthesiology). Must I meet the same requirements as a physician who sees patients face-to-face?

No, a non-patient facing individual or group is subject to fewer requirements under the MIPS, including:

- Excluded from most cost measures (if and when the Cost category is implicated following 2017).
- ACI category weighted to zero.
- Fewer requirements to satisfy the IA category.

A physician is "non-patient facing" if he or she provides 100 or fewer "patient-facing" encounters (such as office visits or surgical procedures); a group is "non-patient facing" if at least 75% of eligible clinicians in the group are non-patient facing.

Frequently Asked Questions

3. What measures should I select?

It is recommended that you choose measures that:

- Are most representative of your practice, such as those that apply to the patients you see or the procedures that you perform frequently to ensure you have a minimum of 20 cases.

- Review the list of measures and the associated CMS developed benchmarks to determine the amount of points you may earn on a measure.

- If possible, avoid reporting on "topped out" quality measures (measures in which respondents generally perform well across the board), because you may have to achieve nearly the highest possible score on the measure to receive more than the minimum number of points for that measure.

- Keep in mind that if you report on a new measure and CMS cannot develop a benchmark for the measure, the maximum number of points you can obtain on the measure is three.

4. How do I meet the Improvement Activities (IA) attestation requirement?

Physicians may select and attest to the completion of any of the CMS designated IAs. Remember that you are attesting to Medicare that you are completing these activities. Attesting to completing an activity without actually doing so may be deemed by the government to constitute fraud and could lead to compliance and potential enforcement risk. CMS has stated that all participants should be able to find IAs appropriate for their practice. Participants in small (fewer than 15 clinicians), rural, or non-patient facing practices have decreased reporting requirements (one high or two medium-weight activities).

Frequently Asked Questions

5. How can I maximize my bonus in 2019?

If you have any experience with the MIPS measures, consider choosing the Full or Partial Participation track over the Minimum Participation track to get the highest possible score and payment adjustment. You must report on any measure for a minimum of 90 days, although CMS has indicated you may be more likely to achieve a higher score if you report data over a longer period. However, physicians who have already participated in the PQRS and Meaningful Use programs may do better over an entire year because there is more time to meet individual measures and achieve a positive score.

6. How can I track my performance?

CMS will provide data to help you prepare for MIPS. Many physicians have participated in the Physician Quality Reporting System (PQRS) and Value Based Modifier (VBM) programs to avoid payment penalties. CMS provides Quality and Resource Use Reports (QRURs) and feedback reports which you can obtain on the CMS website. PQRS and VBM have been rolled into MIPS, and CMS plans to provide similar reports to eligible clinicians in MIPS. These reports contain important information such as the number of physicians billing through your group, the kinds of services your group is providing, and the types of patients "attributed" to your group for purposes of these programs. Your PQRS/VBM QRURs and reports give you a snapshot of your potential scoring under MIPS, and can help you identify trouble spots or potential areas of strength for quality and cost reporting. All QRURs are available on the CMS Enterprise Portal: https://portal.cms.gov/wps/portal/unauthportal/home/. You may need to request the appropriate "role" in the system to view your QRUR; the CMS help desk is available to walk you through this process.

7. I meet the low volume threshold, but my practice plans on reporting as a group. Do I still need to participate in MIPS?

Yes. Once a group decides to report as a group, it must report on behalf of all of the physicians and other eligible providers who bill under the same TIN.

Frequently Asked Questions

8. If I bill under multiple TINs do I need to report separately for each TIN?

Yes. CMS reports data on the basis of TIN/NPI combinations. As such, your participation through each TIN will be treated as a separate record.

9. What are the benefits of reporting as an individual?

For some multi-specialty practices, it may make more sense to report individually so that different quality or IA measures may be used. Also, in instances where individual performance may otherwise be unknown, individual reporting may be beneficial to ensure that bonuses or penalties are equitably applied to individual physicians, rather than to the group as a whole.

10. What are the benefits of reporting as a group?

From an operational and performance-tracking standpoint, reporting as a group may be easier than reporting individually. For practices that have been reporting as a group to programs such as PQRS, the transition to MIPS may be less burdensome if the practice continues to report as a group. Keep in mind, though, that bonuses or penalties will be applied to the group as a whole, so this result may be viewed by some as unfair if some of the group's eligible providers perform poorly and others perform well.

11. Can I report through my EHR?

It depends on your EHR. Contact your EHR vendor as soon as possible to determine their MIPS reporting and tracking capabilities and when these will be available to you. Understanding what your current EHR vendor can do will help you decide how fully you can participate in MIPS in 2017 and how you will report. This action is time-sensitive because time may be needed for training, installing IT infrastructure updates, implementing administrative or clinical workflow changes, and, potentially, engaging a new vendor – so it is crucial to start as soon as possible.

MIPS may be seen as burdensome by many clinicians. Healthcare providers chose their profession because they wanted to treat patients – not do redundant paperwork and documentation just to avoid payment penalties.

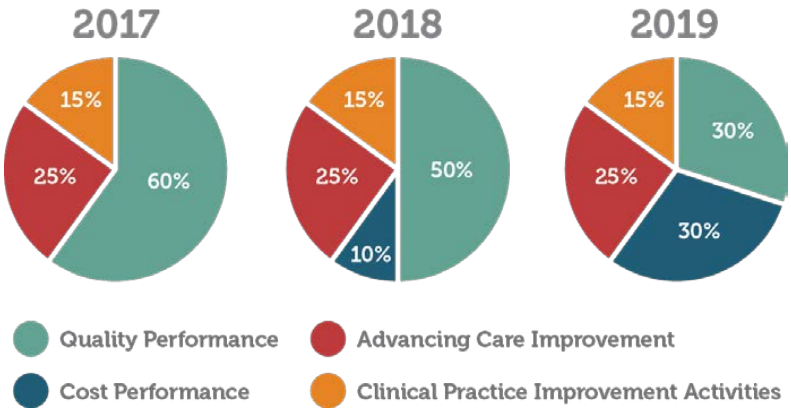
However, we must change this mindset and accept that this value-based payment system is here to stay, and that this is where the US healthcare system is headed. **It is in every clinician's best interest to learn as much about this program as possible, as that is the only way to perform well and reap the benefits of having a high MIPS score.** With great performance, the financial incentives can be substantial – keep in mind that there is an additional $500 million set aside just to reward "exceptional performers", on top of the yearly payment adjustments.

Additionally, your MIPS score can greatly affect your reputation as it will be displayed publicly on the Medicare Physician Compare website. Don't lose patients, credibility, and revenue simply because you are unsure of how to meet the requirements. There are many resources available to you, if you are willing to take the time to familiarize yourself with this program. Here are some helpful links to get you started (sources for this e-book):

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

https://qpp.cms.gov/

https://www.ama-assn.org/practice-management/understanding-medicare-s-merit-based-incentive-payment-system-mips



If you have questions, would like more information on MIPS, or could use some help with avoiding the 4% payment penalty in 2019, email us at admin@lmshealthpro.com OR schedule a FREE Consultation here:

Free MIPS Consultation