A Clear Path to Quality Improvement:

MIPS 2019 AND BEYOND

Strategies to simplify data reporting so you can focus your energy on where it belongs: optimal patient care.
Contents

01  See the Forest for the Trees
02  Get Your Bearings
03  Survey the Changing Terrain
04  Consult Your Atlas
05  Refocus Your Energies
Busy healthcare clinicians have spent many caffeinated mornings and lamp-lit evenings exploring the myriad details of the MIPS program. If you’re feeling overwhelmed by deadlines and changing requirements, you are far from alone.

This guide will help you get up to speed on the latest changes in the MIPS program as you work to educate your team and streamline reporting practices for 2019 and beyond. A clear path to MIPS performance success will help reduce the distractions that interfere with your most essential goal as a medical provider – providing excellent patient care.
A Brief History of MIPS

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA). The bill was designed to create a more predictable and sustainable model for the Medicare Part B reimbursement system. From MACRA was born the Quality Payment Program (QPP), which was designed to lower healthcare costs and improve patient care by rewarding clinicians for achieving value-based care milestones. The QPP consists of two major tracks:

MIPS

Merit-based Incentive Payment System

APMs

Advanced Alternative Payment Models

MIPS is the default track for over 80 percent of clinicians. The Advanced APM route is a bonus track for providers willing to assume a larger financial risk under value-based payment contracts for a large portion of their patient population.

Although the majority of providers will fall into the MIPS track, many physician groups and hospitals will work towards optimizing their performance under MIPS to prepare for future participation in the Advanced APM model.
Below are some of the more significant changes for MIPS Year 3:

- The weight of the Cost category has increased from 10 percent to 15 percent. The weight of the Quality category has decreased to 45 percent.

- Practices of 15 or fewer clinicians will receive an automatic six-point bonus to their Quality score if data for at least one Quality measure is submitted.

- The low-volume threshold now includes a third criterion for determining MIPS eligibility. Clinicians or groups are eligible to report for MIPS if they:
  1. Have $90,000 or more in Part B allowed charges for covered professional services; **AND**
  2. Provide care to 200 or more Part B-enrolled beneficiaries; **AND**
  3. Provide 200 or more covered professional services under the Physician Fee Schedule (PFS).

- New in 2019 - clinicians and practices have the option to opt in to MIPS if they meet or exceed at least one low volume threshold criterion.
Who Qualifies for MIPS?

You are eligible for the MIPS track if:

01. You bill more than $90,000 per year in Medicare Part B allowed charges; AND

02. Provide care to more than 200 Part B enrolled Medicare patients per year; AND

03. Provide more than 200 Medicare professional services; AND

04. You are one of the following:
   - Certified registered nurse anesthetist
   - Clinical nurse specialist
   - Clinical psychologist
   - Nurse practitioner
   - Occupational therapist
   - Physical therapist
   - Physician
   - Physician assistant
   - Qualified speech-language pathologist
   - Qualified audiologist
   - Registered dietitian or nutrition professional
Providers participating in MIPS will earn a performance-based adjustment by reporting patient care data, as well as reporting how their practice used technology during the year. The MIPS scoring method is called the MIPS final score. This score determines the amount providers earn using four weighted performance categories. The categories are:

- **Quality**
  - Previously: The PQRS Program
  - Category weight: 45% of total MIPS score
  - Requirements:
    - Submit six Quality measures.
    - Submit one Outcome measure, unless one is not available in your specialty. In that case, submit a high priority measure in its place.
    - Measures may be submitted via multiple collection types.
  - Getting into the weeds
    - Data completeness refers to submitting data for 60% of patients who meet criteria for the measure:
      - Claims: Medicare Part B patients
      - eCQMs/CQMs/QCDR: all patients across all payers
    - If data completeness is not met, you will earn 1 point for that measure. (Small practices earn 3 points.)

- **Promoting Interoperability**
  - Previously: Meaningful Use (EHR Incentive Program) for Eligible Professionals, Advancing Care Information
  - Category weight: 25% of total MIPS score
  - Requirements:
    - Must report with a 2015 edition CEHRT.
    - Has four objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange and must report certain measures or claim an exclusion.
  - Getting into the weeds
    - Earn points based on the measures performance except Public Health objective measures, which are yes/no.
    - If the measures are not relevant to your practice, the points will be reassigned if you submit an exclusion.
How Does MIPS Work?

**Improvement Activities**

Previously: New Category in 2018

Category weight: 15% of total MIPS score

Requirements:

- Submit up to four Improvement Activity measures to reach a maximum of 40 points. This could be four medium-weighted activities, two high-weighted activities or a combination.
- Practices with fewer than 15 clinicians; practices in rural areas, health professional shortage areas; and non-patient-facing MIPS eligible clinicians need only two Improvement Activities or one high-weighted activity for a total of 20 points.

**Cost**

Previously: Value-Based Modifier

Category weight: 15% of total MIPS score

Requirements:

- This category is claims-based and will be automatically calculated by CMS. No data submission is required.
Reporting Options

Individual
An individual reporter is a single clinician identified by a single National Provider Identifier (NPI) number tied to a single Tax Identification Number (TIN).

Group
A group is defined as two or more eligible clinicians (including at least one MIPS eligible clinician) who share a TIN. Group members are identified by individual NPIs.

Large Practice
Groups of 25 or more providers may submit data using the CMS Web Interface. If this option is chosen, 365 days' worth of data must be reported, including 30+ measures.

Virtual Group
A Virtual Group allows combinations of solo providers or groups of 10 or fewer providers to combine under the umbrella of two or more “virtual” TINs for one performance year. The specialty or location of the practitioners is not important. One caveat is that the low-volume threshold for MIPS participation must still be met. The election deadline for 2020 participation is Dec. 31, 2019.
What happens once my practice’s MIPS final score is determined?

Your MIPS final score has a significant impact on both the reputation and the finances of your practice.

**Reputation**
- CMS publishes the Physician Compare Initiative webpage to help consumers evaluate and compare clinicians and clinical quality statistics. Monitoring this page will allow you to keep track of how your MIPS data is contributing to your efforts.
Financial

The MIPS final score results determine a negative, neutral or positive financial adjustment for clinicians on each Medicare Part B claim. How you choose to participate each year determines your success. The score is based on what you choose to report from the four performance categories and is calculated on a scale from zero to 100 points.

Be aware that the cost for not participating in MIPS is steep. You stand to lose 7 percent of each 2021 Medicare fee reimbursement and the penalty increases yearly.

On the other hand, successful MIPS data reporting means you will avoid the 7 percent penalty and potentially earn a small incentive. These positive payments are also set to increase yearly. Top performers will find themselves eligible for additional bonus money. The number of points earned will determine your opportunities for positive payment adjustments and bonus money.
A Guide to Bonus Points

There are fewer bonus point opportunities in 2019 than there were previously, as items that were once bonus opportunities are now required.

### Quality Score

| 6 points | **Small Practice Bonus:**  
Automatically added for qualifying providers. |
| Up to 6 points | **Additional Quality Measure Submission:**  
Submit an additional Outcome, High Priority or Patient Experience measure after the first required High Priority measure. |
| Up to 6 points | **Certified Electronic Health Record Technology (CEHRT) Submission:**  
Submit Quality measures via CEHRT. |

### PI Score

| 5 points | **Query of Prescription Drug Monitoring Program (PDMP):**  
Verify Opioid Treatment Agreement. |

### Final MIPS Score

| Up to 5 points | **Complex Case Bonus:**  
Automatically added for qualifying providers. |
| Up to 10 points | **Improvement Bonus:**  
Demonstrated year-over-year improvement on Quality Score. |
Ready to Explore a Bit More?

A few deadlines:
The last day to submit performance data for 2019 is March 31, 2020. For the Quality and Cost categories, this would mean data that was tracked from Jan. 1, 2019 through Dec. 31, 2019. For the Promoting Interoperability and Improvement Activities, this would mean data tracked any consecutive 90 days during the year.

How should I report my data?
You may use different methods to report different categories and, as of 2019, you may use multiple collection types within the Quality category.
Reporting Options:

- Qualified Clinical Data Registry (QCDR)
- Certified Electronic Health Record Technology (CEHRT)
- Qualified Registry (QR)
- Medicare Part B claims-based reporting
- CMS Web Interface (for groups of 25 or more eligible clinicians)
- Consumer Assessment of Healthcare Providers and Suppliers (CAHPS) for MIPS (counts as one Quality measure; remaining measures must be reported using one other reporting method)

Some medical specialties have already made the shift away from the claims-based reporting system. Others, for now, continue to use this familiar payment mechanism. However, according to CMS, “claims reporting captures only about 40% of eligible reporting opportunities.”

Moving to a registry may appear to be somewhat of a challenge at first, but taking this step can offer significant opportunities to improve performance, not just with MIPS compliance, but also in the realm of patient care and communication.
A Navigating Partner: How a Registry Can Help

A registry partner can help you analyze your current performance on data submission and quality measures. This information can then be used to determine the way forward by helping you select which reporting strategy is most appropriate for your practice or network. The result should be one integrated system that provides a view of all involved clinicians’ performance across all four MIPS categories.

The registry then takes on the job of MIPS reporting: aggregating, analyzing, calculating and submitting the data on your behalf. These types of solutions can be tailored to fit any size organization, from large multidisciplinary networks to small group or solo clinicians.

With the data reporting taken care of, you can focus on improving patient care and MIPS reimbursement by viewing and sharing the collected information all in one place. Aligning clinician measures in this way allows you to create and optimize shared goals between clinicians in various care settings.
Refocus Your Energies

- Patient care improvements by individual clinicians will advance some of the larger shared goals of the healthcare community. Switching from a volume-based to a value-based payment program moves us closer to achieving the aims of better care, healthier communities and lower costs.

- More importantly, spending time on planning, outreach and care coordination should allow for increased ability to offer cost-effective and patient-centered care.

The frequent changes in today’s healthcare environment can be dizzying and distracting. Despite the increasing complexities, the ever-present need for compassionate medicine remains the same. A guiding partner can help you take on the challenges related to MIPS reporting so you can concentrate on what matters most: caring for your patients.
Contact Premier today to assess the impact of MIPS on your practice, determine your best reporting method and optimize your strategy.