revolutionEHR
freedom to focus

MIPS Summary and FAQ

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created the Quality Payment Program which moves Medicare toward their goal of paying for value and better health care. There are three principles under MACRA:

- Repeal of the Sustainable Growth Rate Formula for Medicare Physician Fee Schedule adjustments
- Creation of a new framework for rewarding providers for value instead of volume
- Combine multiple quality reporting programs (MU, PQRS, VM) into one new system

The Quality Payment Program has two paths for eligible clinicians:

1) The Merit-Based Incentive Payment System (MIPS)
2) Advanced Alternative Payment Models (APMs)

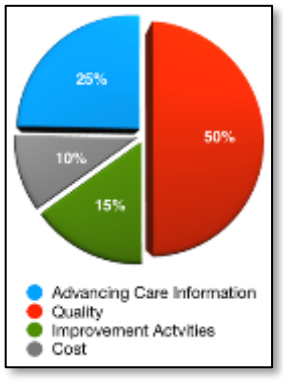
Provider reimbursements for Medicare Part B services in the years ahead will be determined by participation in one of these two paths. The first performance period (the time period where participation is "graded") is 2017. Performance in 2017 will affect 2019 Medicare Part B reimbursements. Similarly, reimbursements for any year after 2019 will be determined based on performance two years earlier. For example, reimbursements in 2020 will depend on how well a clinician performs in 2018.

The Merit-Based Incentive Payment System (MIPS) represents the path that most clinicians will be following in the early days of the Quality Payment Program. In 2017, MIPS created a final score of 0-100 for each clinician based on their performance in 2017 across 3 categories:

- **Advancing Care Information** (formerly known as Meaningful Use) - 25% of MIPS composite score in 2019
- **Quality** (formerly known as PQRS) - 60% of MIPS composite score in 2019
- **Improvement Activities** - 15% of MIPS composite score in 2019

The scoring system will change slightly in 2018 by adding a new performance category, Cost, and weighting it at 10% of the clinician's final score:

- **Advancing Care Information** - 25% of MIPS final score in 2020
- **Quality** - 50% of MIPS final score in 2020
- **Improvement Activities** - 15% of MIPS final score in 2020
- **Cost** – 10% of MIPS final score in 2020



How does MIPS alter Medicare Part B reimbursements?

Each clinician's MIPS final score gets compared to a value known as the performance threshold. In 2017 and 2018, the performance threshold was set based purely on rulemaking. However, 2019 and beyond will set the performance threshold based on either the mean or median MIPS final score of all other clinicians in the program. Regardless of how the performance threshold is set:

- A MIPS final score above the performance threshold will receive an increased reimbursement
- A MIPS final score below the performance threshold will receive a decreased reimbursement
- The further away from the performance threshold a provider's MIPS final score is, the more significant the upward or downward revision of reimbursements

How much will MIPS affect my Medicare Part B reimbursements?

- as much as +/- 4% in 2019 (based on 2017 performance)
- as much as +/- 5% in 2020 (based on 2018 performance)
- as much as +/- 7% in 2021 (based on 2019 performance)
- as much as +/- 9% in 2022 (based on 2020 performance)

Each year between 2019 and 2024 will also offer the potential for exceptional performance bonuses ranging from 0.5-10%.

Is it true there are no longer individual penalties for PQRS, MU and the Value-based Payment Modifier?

2018 is the last year providers will experience individual penalties related to lack of participation in these quality reporting programs. Starting in 2019, reimbursements can be adjusted up or down based on a provider's actual performance scoring within the MIPS categories in 2017.

How is Advancing Care Information different from Meaningful Use?

Advancing Care Information does away with measure thresholds that need to be surpassed and many of their exclusions. In exchange, Advancing Care Information asks you to:

- Demonstrate a base level of participation by reporting successfully for each for 4 required measures (a numerator of at least 1 or a "Yes" for the SRA measure)
- Strive for optimal performance in the measures you feel are most relevant to your practice.

The sum of your base participation, statistical performance in each of the included measures and potential bonus points for registry engagement contributes to your score for the Advancing Care Information category. The better your performance, the better your score.

revolutionEHR
freedom to focus

What's new in Advancing Care Information for 2018?

- Minimum 90-day performance period
- 2014 Edition or 2015 Edition EHR software allowed
- Bonus points if clinician uses 2015 Edition and participates in ACI measures (aka Stage 3 measures)
- Hardship opportunity for small practices (≤ 15 clinicians) with "overwhelming barriers that prevent the MIPS eligible clinician from complying with the requirements"

How is the Quality category different from PQRS?

PQRS asked you to report 9 measures across 3 "domains" more than 50% of the time they applied throughout the year. In 2017, "Quality" asks you to report on 6 measures more than 50% of the time they apply. One of these six must be an outcome or other high-priority measure. 2018 raises the data completeness requirement to 60% of applicable cases.

As an example, if you see 100 glaucoma patients during 2018, it's expected that you'd report a glaucoma-related quality measure on at least 60 of those patients (60%) for the measure to be scored based on performance.

Your scoring within each measure is compared to a benchmark of performance two years earlier to arrive at your final score for the measure. The sum of your measure scores and any bonus points is used to determine your Quality category score.

What's new in Quality for 2018?

- Full calendar year performance period
- Must report measures on at least 60% of applicable cases for performance to be scored
- Opportunity to earn bonus points for year-over-year improvement
- Continuation of 3-point base score for any measure successfully submitted

It sounds like Advancing Care Information and Quality are focusing on my performance instead of just satisfying requirements?

That's right. The better you do, the better your chances for increased reimbursements and vice-versa.

What is the Improvement Activities category all about?

By definition, improvement activities are actions that CMS believes will lead to better patient outcomes. Examples include offering expanded practice access, surveying the patient experience and engagement with a qualified clinical data registry. There are over 90 activities listed in the rule. You are free to pick the activities you'd like to participate in and CMS will expect you to be involved with them for at least 90 days during the year to receive credit.

Each activity is weighted as "high" or "medium" based on how it aligns with national public health priorities. That weighting carries a point total with it (20 for "high", 10 for "medium").

Full credit for the category is achieved with 40 points. CMS has continued its easing of the requirements in this category in 2018 for clinicians in smaller practices (≤15 providers) resulting

in the need for those clinicians to only participate in 1 "high" or 2 "medium" activities for full credit.

Certain activities also offer a bonus if they are achieved using certified EHR technology (CEHRT).

What's new in Improvement Activities for 2018?

- Minimum 90-day performance period
- New potential activities added including credit for clinicians who host students during clinical rotations
- More activities eligible for CEHRT bonus
- Reweighting of some existing activities (i.e. TCPI participation shifts from "High" to "Medium" weighting)

What's the Cost performance category all about?

The Cost category implements measures from the value-based payment modifier system to measure the costs associated with care provided by the clinician. Two measures are utilized:

- Medicare spending per beneficiary
- Total per capita costs for all attributed beneficiaries

Not every clinician will have cost measures attributed to them. When a Cost performance category score is not possible, the 10% MIPS final score weighting of Cost will shift to the Quality category.

Cost category data is aggregated by Medicare based on claims submitted during the performance period so data tracking and data submission is not required of the clinician.

Whoa! That sounds awfully complicated. Can you make the Cost performance category easier to understand?

Clinicians don't need to submit any data here. Provide precisely the care your patients need at each visit, no more and no less.

Are there other opportunities for bonus points in 2018?

Yes! Beyond the bonus points available within the individual performance categories, the following opportunities exist:

- Small Practice Bonus – 5 points automatically added to the MIPS Final score of any clinician in a practice of 15 or fewer clinicians who submits data for at least one performance category
- Complex Patient Bonus – up to 5 points for the management of complex patients as determined by Hierarchical Category Coding and Medicare/Medicaid dual-eligibility

ratio. Requires data to be submitted for at least one performance category.

How will I report for MIPS?

As noted earlier, providers do not need to report anything additional for the Cost category. The three other categories allow various reporting methods:

Advancing Care Information	Attestation, Qualified Clinical Data Registry, Qualified Registry, EHR
Quality	Claims, Qualified Clinical Data Registry, Qualified Registry, EHR
Improvement Activities	Attestation, Qualified Clinical Data Registry, Qualified Registry, EHR

**note: claims-based reporting for Quality not available for practices reporting as a Group*

Providers can report by different methods for each category (i.e. claims for Quality and attestation for Advancing Care Information), but are encouraged to not report by multiple methods within each category.

What are my participation options?

In general**,** a clinician can participate in MIPS as an individual, a group, or a virtual group.

Clinicians choosing to participate as individuals submit their own individual performance data and are evaluated on those statistics alone.

Clinicians in practices with >1 clinician who elect to report as a group must add all clinician performance data together and submit it. Each eligible clinician within the group then has their reimbursements modified based on the group's performance data.

A virtual group is a collection of clinicians under different Tax IDs (i.e. different businesses) that mutually decide to join forces to participate in MIPS. Just like a regular group, performance data is pooled from all providers in the virtual group, reported that way, and then reimbursement decisions are made based on the aggregated set of data.

The ultimate decision about which way to participate requires consideration of several factors including clinicians in the practice, each clinician's eligibility, Part B Medicare volume of each clinician, etc.

Will everyone be subjected to MIPS?

No. Three groups of providers would not be expected to report for MIPS in 2018:

- Providers new to Medicare Part B participation in 2018

- Providers below $90,000 in Medicare Part B allowable charges **OR** 200 Part B beneficiaries during a specific period of time
- Providers participating to a certain level in advanced Alternative Payment Models

Is it true that CMS has extended flexibility for reporting periods in 2018?
Yes. The Advancing Care Information and Improvement Activities category will have a minimum of "any 90 consecutive days" performance period while Quality and Cost will require the full calendar year.

How else might MIPS information affect me?
By regulation, MIPS information will be made available on Medicare's Physician Compare website: https://goo.gl/Lbgbml. Physician Compare will allow the public to search for providers within a specific zip code or city, see their MIPS composite scores, see how they performed within the various performance categories, how they fared on specific measures, and how they compared the national averages.

Where can I learn more?
CMS has made many resources available on their Quality Payment Program website: https://qpp.cms.gov