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2019 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 clinicians for value instead of volume
- Combine multiple quality reporting programs (MU, PQRS, VM) into one new system

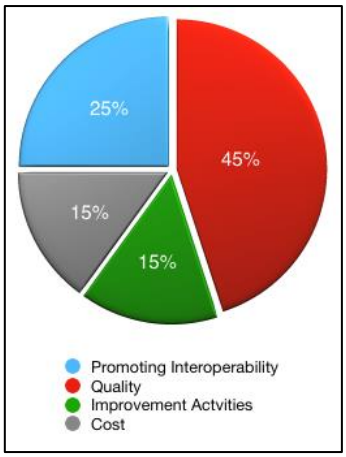
The Quality Payment Program has two paths for eligible clinicians:

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

Clinician 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") was 2017. Performance in 2017 determined how 2019 Medicare Part B reimbursements would be adjusted. Similarly, reimbursements for any year after 2019 will be determined based on performance two years earlier. For example, reimbursements in 2021 will depend on how well a clinician performs in 2019.

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 2019, MIPS will assign each eligible entity with a final score of 0-100 based on their performance across 4 categories:

- **Promoting Interoperability** - 25% of MIPS final score
- **Quality** - 45% of MIPS final score
- **Improvement Activities** - 15% of MIPS final score
- **Cost** – 15% of MIPS final score



How does MIPS alter Medicare Part B reimbursements?
Each clinician's performance is the 4 slices of the pie to the right determines their final score. That final score then gets compared to a value known as the performance threshold. In the early days of the program, CMS has slowly increased the performance threshold to increase expectations on doctors. In time, the performance threshold will be set based on the average performance of doctors participating 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 clinician'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 was the last year clinicians experienced individual penalties related to lack of participation in these quality reporting programs. Starting in 2019, reimbursements will be adjusted up or down based on a clinician's actual performance scoring within MIPS.

How is Promoting Interoperability different from Meaningful Use?

Promoting Interoperability does away with measure thresholds that need to be surpassed. In exchange, Promoting Interoperability in 2019 asks you to:

- Demonstrate a base level of participation by reporting successfully for each of the 6 required measures (a numerator of at least 1 for numerical measures, a "Yes" for any Yes/No measure, or qualify for an exclusion)
- Complete a security risk analysis during the 2019 calendar year

Statistical performance within the EHR determines how many "points" a clinician receives. As an example, if a clinician achieved 90% for a measure worth 10 points, the clinician would receive 9 points. The more points received, the higher the Promoting Interoperability score and the higher the overall MIPS Final Score.

What's new in Promoting Interoperability for 2019?

- Minimum 90-day performance period
- 2015 Edition certified EHR software required
- No longer bonus point opportunities for completing an Improvement Activity via CEHRT
- 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 2019, "Quality" asks you to report on 6 measures more than 60% of the time they apply. One of these six must be an outcome or other high-priority measure.

As an example, if you saw 100 glaucoma patients during 2019 and you intended to report a glaucoma-related measure, it's expected that you'd report that measure on at least 60 of those patients (60%) for the measure to be scored based on performance. Without hitting 60% data completeness, CMS declares the measure to be an inaccurate indicator of quality of care and assigns the lowest possible score.

Assuming data completeness and case minimums (≥ 20 patients) have been met, 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 2019?

- 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
- 6 bonus points awarded to clinicians in small practices (≤ 15 clinicians)
- Continuation of 3-point base score for small practices for any measure successfully submitted

It sounds like Promoting Interoperability 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 100 activities listed in the 2019 final rule and you can think about that list as a "menu". 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 2019 for clinicians in smaller practices (≤15 clinicians) resulting in the need for those clinicians to only participate in 1 "high" or 2 "medium" activities for full credit.

What's new in Improvement Activities for 2019?

- Minimum 90-day performance period
- New activities added including credit for clinicians who provide care to underserved patients at no cost (i.e. VISION USA)
- No activities eligible for CEHRT bonus in Promoting Interoperability category

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 global measures and eight episode-based measures are utilized. Importantly, these measures are determined completely by CMS. No data tracking or submission is required of clinicians.

Each measure has a case minimum and CMS believes it's possible that few clinicians will actually exceed those and, in turn, qualify for a Cost category score. Thus, they continue to explore ways to expand the analysis period so that every clinician will have attributed measures and a Cost score. When a Cost performance category score is not possible, the 15% weighting of Cost will shift to the Quality category.

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, and the Cost category will unfold properly. Focus your time and attention on the categories you have direct control over: Promoting Interoperability, Quality, and Improvement Activities.

Are there other opportunities for bonus points in 2019?

Yes! Beyond the bonus points available within the Quality category, CMS continues to work to "level the playing field" by ensuring that those who care for complex patients (and the patients themselves) aren't penalized. Clinicians can receive up to 5 points for the management of complex patients as determined by Hierarchical Category Coding and Medicare/Medicaid dual-eligibility ratio. These calculations are determined by CMS and applied to a clinician's final score.

How will I report for MIPS?

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

Promoting Interoperability	Log in and Attest, Log in and Upload, EHR Direct
Quality	Part B Claims, Log in and Upload, EHR Direct
Improvement Activities	Log in and Attest, Log in and Upload, EHR Direct

Clinicians can report by different methods for each category (i.e. Part B claims for Quality and Log In and Attest for Promoting Interoperability).

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 that way. 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 clinicians 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 clinicians would not be expected to report MIPS data in 2019:

- Clinicians new to Medicare Part B participation in 2019
- Clinicians participating to a certain level in advanced Alternative Payment Models
- Clinicians below $90,000 in Medicare Part B allowable charges **OR** 200 Part B beneficiaries during a specific period of time **OR** 200 covered professional services
    - A clinician needs to exceed all three values to be definitively included in MIPS for 2019

But if I'm considered exempt, how do I get paid more for my Part B services in the future?
Great question and it's one that didn't have a good answer until now. It's true that a clinician exempt from MIPS is also exempt from CMS reimbursement revision. And that hasn't sat well with many because there was no way into the program if a clinician's Part B volume didn't exceed the threshold. Through official feedback and consideration, though, CMS has implemented a process for 2019 whereby an exempt clinician could "opt in" and be included in reimbursement revision.

Great! How do I opt-in?
CMS believes that they are required to have a clinician exceed a threshold value to allow their inclusion in MIPS. Thus, to qualify for opt-in a clinician would need to exceed 1 or 2 of the

threshold values posted above. CMS believes the opt-in process will allow nearly 150,000 more clinicians the ability to be included in reimbursement revision. The formal opt-in process will take place on the same QPP website that is used for eligibility lookup and data submission.

Do I need to tell CMS that I'd like to opt in before 2019 starts?
No. A clinician can participate to the best of their ability throughout 2019, analyze their data at the end and then make the decision about opting in or not. Importantly, once the decision is made for a given year, it is irrevocable. Thus, if a clinician is on the fence there's no harm in waiting to make the decision.

Is it true that CMS has extended flexibility for reporting periods in 2019?
Yes. The Promoting Interoperability 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. Within Promoting Interoperability, this flexibility will afford time for clinicians to implement 2015 Edition certified technology.

How else might MIPS information affect me?
By regulation, MIPS information will be made available on Medicare's Physician Compare website. Physician Compare will allow the public to search for clinicians 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.