Whitepaper

MIPS Guide

Everything you need to know about MIPS 2018/19

Broad Topic: MIPS guide

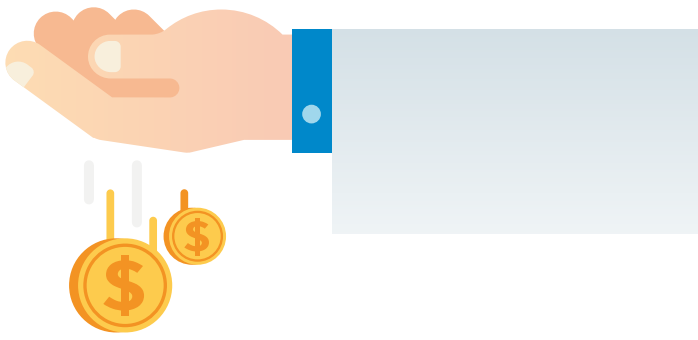
Is your practice ready for MIPS? With the Medicare Access and CHIP Reauthorization Act (MACRA) legislation which was passed in 2015 by president Barrack Obama, CMS aims at providing the people with qualitative healthcare, rather than the quantitative healthcare. Along with that CMS began the MIPS program in 2017 which offers a payment adjustment process based on the qualitative performance of the practices.

The best way to get ready for MACRA and MIPS is to satisfy Meaningful Use Stage 2 requirements and continue to work on meeting Clinical Quality Measures through the use of an ONC 2015 certified EHR solution.The purpose of this paper is to simplify the payment adjustment process of MIPS along with the options that the practitioners have in regards to it.

Let's begin!

The main questions addressed in the paper are:

- What is MACRA?
- What is MIPS and what is its eligibility?
- How is the performance measured?
- How are the practitioners paid?
- How can practitioners get the best score?



What's MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed on April 16, 2015. This legislation was passed by with the consent of the majority in the House of Representatives.

MACRA offers new reimbursement framework which rewards the clinician for giving better care instead of more service. This program is targeted to achieve

- Quality
- Value
- Accountability

This Quality Payment Program is designed to improve the healthcare process by:

- Annulling the Sustainable Growth Rate Formula.
- Changing the tradition of clinician's reimbursements which were based on volume rather than value.
- Streamlining multiple quality programs under the new Merit-Based Incentive Payment System.
- Enabling practitioners to receive bonus payments for participation in the eligible Alternative Payment Models (APM).

What's New?

MACRA made some changes on March 2, 2018, and these changes pro-dominantly supported the small practices (1 to 15 practitioners) that they can skip participation altogether. Here are the key changes proposed in the 2018 performance period.

1. The clinicians now have the option to report their performance individually or band together in the form of groups and report in Virtual groups.

2. CMS added bonus points to the MIPS scoring methodology for small practices to increase their performance with respect to the quality of healthcare.
3. MIPS composite score is adjusted in order to get low penalty rates.
4. The amount of Medicare Part A and B revenue that must be at risk to qualify as an advanced Alternative Payment Model was extended for two years.

Goals of MACRA:

Currently, MACRA has two primary goals which include:

- The first goal of MACRA is to improve 30% of the Medicare Outcomes by converging the clinicians towards the Accountable Care Organizations (ACO'S) instead of fee-for-service and to touch 50% at the end of 2018.

- The second goal of MACRA is to reach 85% percent of all traditional Medicare payments to quality instead of quantity by 2016 and 90% percent by the end of 2018 through Programs such as the Hospital Value-Based Purchasing and the Hospitals Readmissions Reduction Programs.

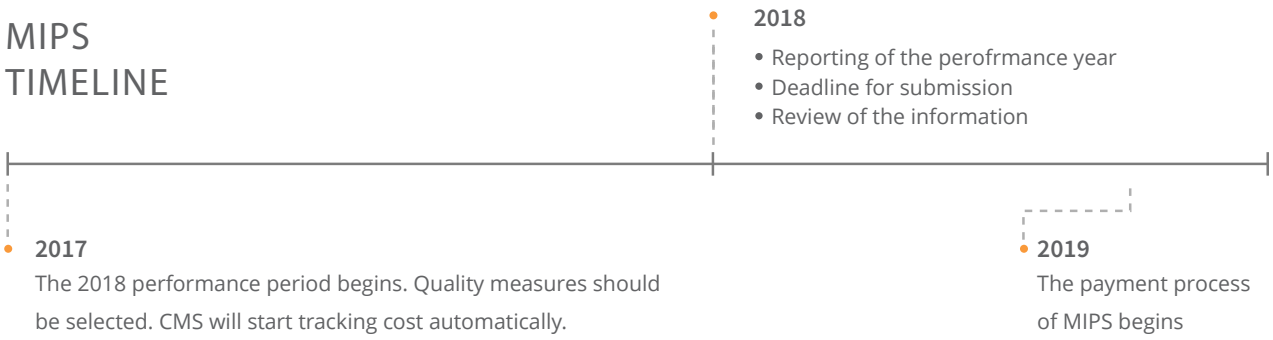
MACRA combines the Physician Quality Reporting System (PQRS), Value-based reimbursements and the Electronic EMR incentive Payment Program into one single program called Merit-based Incentive Payment System (MIPS).

What is MIPS?

Practitioners are often confused regarding the MIPS program. Well, the Merit-Based Incentive Payment System (MIPS) is one of the famous quality payment programs under CMS which grants performance-based payments to Medicare Part B providers. MIPS is the combination of three medical programs – the Physician Quality Reporting System, the Value-based Payment Modifier and the Medicare Electronic Health Record (EHR) Incentive Program.

MIPS Timeline

As for the timeline of MIPS, it is designed in such a way that the payment adjustment process would occur after two years of the reporting year. For instance, the performance information of 2017 which was due till March 31st, 2018 would grant the payment adjustments in 2019. This process would allow CMS almost a year's time to analyze the information and assign the MIPS Final Score to each clinic.



As to what is the MIPS Final Score? That will be discussed later on in the paper.

What to report?

The four reporting categories for MIPS are all assigned a certain weight which varies over the years. The different weights with respect to their fiscal years are described below.
For the first payment adjustment year (2019) the weight distribution is as follows:

- Quality: 60%
- Promoting Interoperability(PI): 25%
- Improvement Activities: 15%

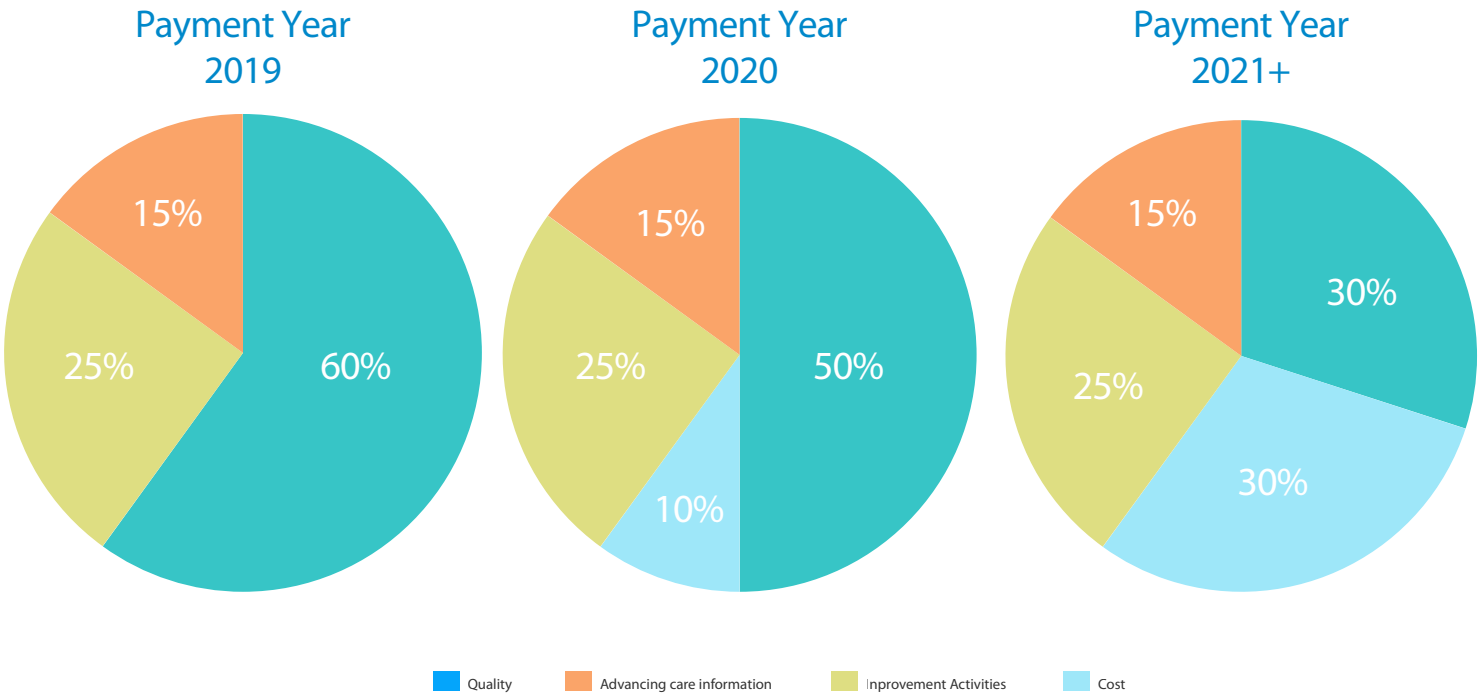
For the second payment adjustment year (2020) the weight distribution is as follows:

- Quality: 50%
- Promoting Interoperability(PI): 25%
- Improvement Activities: 15%
- Cost: 10%

For the third payment adjustment year and beyond (2021) the weight distribution is as follows:

As for the timeline of MIPS, it is designed in such a way that the payment adjustment process would occur after two years of the reporting year. For instance, the performance information of 2017 which was due till March 31st, 2018 would grant the payment adjustments in 2019. This process would allow CMS almost a year's time to analyze the information and assign the MIPS Final Score to each clinic.

- Quality: 30%
- Promoting Interoperability(PI): 25%
- Improvement Activities: 15%
- Cost: 30%

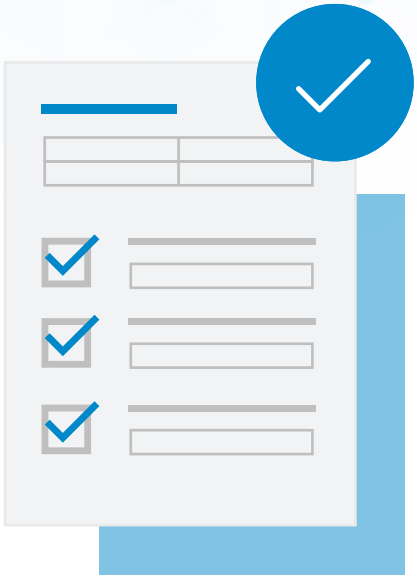


Are You Eligible for MIPS?

This is one of the primary aspects of confusion for the clinicians when it comes to MIPS program. However, the solution is a quite simple one. For the first two performance years of MIPS, an Eligible Clinicians defined by CMS are:

1. Physicians
2. Physician Assistants
3. Nurse Practitioners
4. Clinical Nurse Specialist
5. Certified Registered Nurse Anesthetist

In 2019, CMS will be including even more categories such as:



1. Physical/Occupational Therapists
2. Speech/Language Pathologists
3. Audiologists
4. Dietitians/Nutrition Professionals
5. Clinical Social Workers
6. Nurse Midwives

Clinicians Exempted from MIPS

CMS continuously refines this program, including eligibility merits and latest regulatory changes in order to improve it for future years. So these exemptions are:

- The ones who are not listed above.
- The clinicians who enlist themselves in Medicare Industry for the first time in 2018.
- Clinicians who participate in Advance APM.
- Clinicians or groups that have earned $90,000 or less in Physical Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries.
- Clinicians or groups that have 200 or fewer Medicare Part B FFS beneficiaries.

Voluntary Participation:

Those clinicians who are not qualified for the MIPS eligibility criteria can voluntarily submit their data individually in order to obtain feedback and to prepare themselves for the future. Moreover, clinicians who will submit their data voluntarily will not be subjected to a positive or negative payment adjustment.

How to verify your eligibility?

Use Quality Payment Program website tool. This tool provides you complete details by entering NPI number. It helps you to understand the practice and whether the practice is eligible for high scorings or not. Moreover, CMS will be mailing out the list of the respective practices and name of the clinicians who are participating in the Medicare.

Are these requirements applicable to all specialties?

These Eligibility requirements are for all specialties. If you satisfy these requirements only then you will be enrolled in this program.

Is there any penalty if you don't qualify for MIPS?

There is no penalty if you don't qualify for the MIPS but as mentioned above Voluntary Participation may help you in future enrollment.

This leads us to our next discussion regarding the options that practitioners have within the MIPS program.

What Options Do Eligible Practitioners Have?

As a practitioner, it's quite normal to feel worried about the MIPS initiative. However, that worry can be simplified be explaining the four options that the practitioners have with regards to MIPS.

1. Not Participate:

Firstly, practitioners who are eligible and choose not to participate in the MIPS program at all. However, by choosing to do so they would have to incur the full negative payment adjustment for that performance year. For instance, practitioners who did not participate in MIPS by

2. Submit Test Data:

The second option that practitioners are given is to simply avoid the negative payment adjustment only. By using an ONC 2014 or 2015 edition certified EHR solution, practitioners can report minimum information which will enable them to avoid the negative payment adjustment. The minimum information can be one measure of quality or one improvement activity. In this case, the practitioners would not receive any positive reimbursement or incentive even if they perform exceptionally well.

3. Partial Year Submission:

The third option for the practitioners is to report the full performance information regarding the four performance categories for a minimum of 90 days with the help of certified EHR solution. This will enable the practitioners to gain a small positive or neutral payment adjustment based on the MIPS Final score.

4. Full Year Submission:

The last and the most profitable option for practitioners is to report their full year's performance based on the four categories mentioned previously. They would require an ONC 2014 or 2015 certified EHR for their reporting and earn either a neutral payment or a large payment adjustment based on their MIPS Final Score.

How is Performance Measured under MIPS?

How does MIPS measure the performance of a clinical practice? MIPS is a Budget-Neutral payment program laid down on four performance categories that stimulate clinicians to take substantial measures that are beneficial to their practice. These four categories include:

- Quality
- Promoting Interoperability (PI)
- Improvement Activities (IA)
- Cost

An Eligible Clinician's (EC) practice's performance is calculated by combining these four weighted category scores in order to get MIPS Composite Performance Score (CPS), also known as the MIPS Final Score. This score, later on, helps in their payment and reimbursement adjustments.

So many questions pop-up with regards to the performance categories information like:

- *How to satisfy these categories according to the weight?*
- *How to end up getting good MIPS Final score?*
- *How is this specific weight calculated?*
- *How to avoid penalties?*

All of these questions are catered to later on within the paper.

Quality

The Quality category of MIPS is simply a replacement of the Physicians Quality Reporting System (PQRS). This program requires an eligible clinician to report to CMS about the quality measures taken to improve patient outcomes, apt use of clinical resources, efficiency, and patient's care experience. Practitioners are required to choose six measures that best suits their practice.

What are these six measures and how to choose?

These Electronic Clinical Quality Measures are offered by many certified EMR systems thus the need arises for choosing the best EMR for your practice. For instance, there are different measures for each sub-specialty like for an Endocrinologist:

- CMS122v5-Diabetes: Hemoglobin A1C (HbA1c) Poor Control (>9%)
- CMS123v5-Diabetes: Foot Exam

Here is a list of few eCQMS:

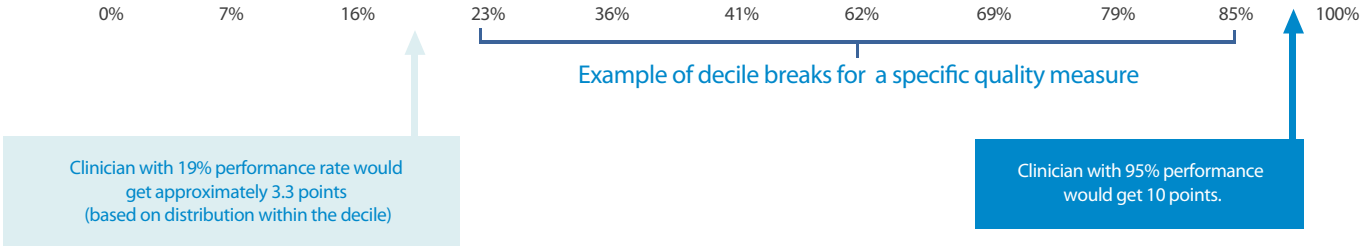
- CMS124v5-Cervical Cancer Screening
- CMS125v5-Breast Cancer Screening
- CMS127v5-Pneumococcal Vaccination Status for Older Adults
- CMS130v5-Colorectal Cancer Screening
- CMS131v5-Diabetes: Eye Exam
- CMS139v5-Falls: Screening for Future Fall Risk
- CMS147v6-Preventive Care and Screening: Influenza Immunization
- CMS149v5-Chlamydia Screening for Women
- CMS156v5-Use of High-Risk Medication in the Elderly
- CMS165v5-Controlling High Blood Pressure

For each measure, Decile and Possible Points table are devised in order to get optimum outcomes.

Decile: sub-categories for each measure with different performance levels. For example, if your performance rate is 65% then clinician would fall in Decile 6 range. Similarly, Decile 10 is for performance rate above 85%. These rates vary from measure to measure according to sub-specialty.

Possible Points: For each Decile range, there are points that a clinician can earn for its quality performance.

Decile	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Possible Points	1.0-1.9	2.0-2.9	3.0-3.9	4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10



How is the score calculated for the Quality category?

Quality category contributes 3-10 point in clinician's MIPS Final Score if the submitted performance data is authentic and reliable against a benchmark (minimum requirement). According to CMS:

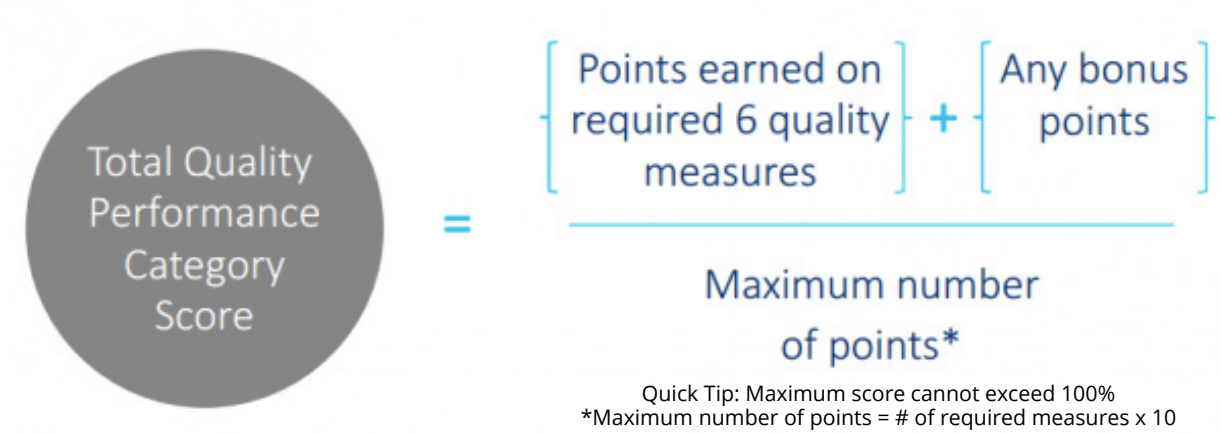
- For each measure, there is a benchmark.
- The data provided by a clinician should meet the minimum case number requirement (≥ 20 cases).
- At least 50% of the data needs to be submitted for each measure.

Once the data is submitted, CMS compares it with an eligible clinician's records which are published benchmarks, based on the national performance. Later on, the performance data is analyzed and points are assigned according to the Decile range. For each measure, a clinician can score up to 10 points.

How to get Bonus Points?

A clinician can score bonus points if they satisfy any one of the conditions given below:

- For each additional outcome and patient care measure, a clinician is rewarded with 2 points.
- For each high priority measure submission, 1 point is awarded.
- 1 bonus point for using a Certified Electronic Health Record Technology (CEHRT) to submit measures to CMS.



Quick Tip: Maximum score cannot exceed 100%
*Maximum number of points = # of required measures x 10

Promoting Interoperability:

CMS has renamed Advancing Care Information Performance category to Performance Interoperability (PI) in order to highlight the patient involvement and to digitalize the exchange of health-related information using a certified EMR solution. This category replaces the Medicare EHR Incentive Program (Meaningful Use).

What's the Medicare EHR Incentive Program (Meaningful Use)?

In 2011 CMS introduced this Incentive program in order to inspire Eligible Clinicians and organizations to implement this PI program. There are three waves of this program:

Stage 1 includes the digitalization of the clinical data and providing the patients with the electronic copies of health-related information.

Stage 2 comprises of the expansion in stage1 with focusing on advancement in clinical processes with the intention of the improvement in the health outcomes.

Stage 3 is an addition to stage2 with a few additional objectives to further improve the healthcare process.

How to calculate the PI Category score?

There are certain measures that clinician should look for when they are deciding between EMR vendors. Its formula is:

PI Category Total Score = Base Score + Performance Score + Bonus Score

There are four Base Score measures:

Security Analysis: Your EMR needs to be certified in accordance with the requirements of 45CFR 164.308(a)(1), including encryption of the Electronic protected health information (ePHI) data creation and maintenance along with the HIPPA-compliance.

Security Analysis: Your EMR needs to be certified in accordance with the requirements of 45CFR 164.308(a)(1), including encryption of the Electronic protected health information (ePHI) data creation and maintenance along with the HIPPA-compliance.

Digital Prescribing System: Eligible clinician needs to write one prescription that is formulated and transmitted by the certified EMR system.

Patient Involvement: Patient should be given an access to its online medical history, treatment plan, and prescription if their physician is MIPS eligible candidate.

Health Information sharing: MIPS eligible clinician needs to share the patient prescription with the pharmacist and similarly, other relevant data for the relevant person.

Performance Score Measures are:

Measure	Performance Score Weightage
Patient Involvement	20%
Health Information Sharing	20%
Secured Messaging	10%
Online View and Download Facility	10%
Medical Reconciliation	10%
Patient Related Education	10%

Secured Messaging: For at least one patient checked by the MIPS eligible clinician, an encrypted message was sent using the electronic messaging function or a response message is sent by the patient, during the performance period.

Online View and Download Facility: At least one patient seen by the eligible clinician have an option to view, download and transmit their health-related information to a third during the performance period.

Medical Reconciliation: during a performance period, at least one transition of care in which the patient is transitioned into the care of the MIPS eligible clinician.

Patient Related Education: The MIPS eligible clinicians need to use a certified EMR in order to provide access to patient-related information materials to at least one unique patient.

Bonus Score: In order to receive the 5% bonus score practitioner can report additional public health data registry to the Immunization Registry Reporting.
These are the score requirements of ACI/PI program for a qualified EMR.

Improvement Activities

This category of the MIPS is designed to encourage the eligible clinicians to engage in the activities that improve outcomes. The main goal of such activities is to

- Improve the Care Process.
- Enhance Patient Involvement.
- Increase Access to Care.

There are several programs that are introduced by CMS for the practitioners and a few of them are listed below:

Administration of the AHRQ Survey of Patient Safety Culture: This program has a medium score weight and falls under the sub-category of Patient Safety & Practice Assessment.

Annual registration in the Prescription Drug Monitoring Program: This program is designed for the eligible clinicians for a time frame of a minimum of six months. This program falls under the sub-category of Patient Safety & Practice Assessment and has a minimum weight.

Anticoagulant management improvements: Eligible Clinicians who prescribe oral vitamin K antagonist therapy need to monitor certain things like Patient Education, Systematic INR testing, follow-ups, patient results and dose-decisions for the first performance year. This program falls under the category Population Management and its score weight is high.

Collection and Follow-up on patient experience and satisfaction data on beneficiary engagement: This improvement program falls under the category of Beneficiary Engagement with the high score ratings.

Cost

This performance category is the replacement of Value-Base Reimbursements. The cost will be calculated by CMS based on merits laid down by Medicare claims. In the start of 2018, this cost will also be influenced by the MIPS Final Score.

How is the score calculated in this category?

Similar to the Quality performance, the cost score is also calculated by measuring up against benchmarks and points are rewarded according to the Decile system.

What are the measures for this category?

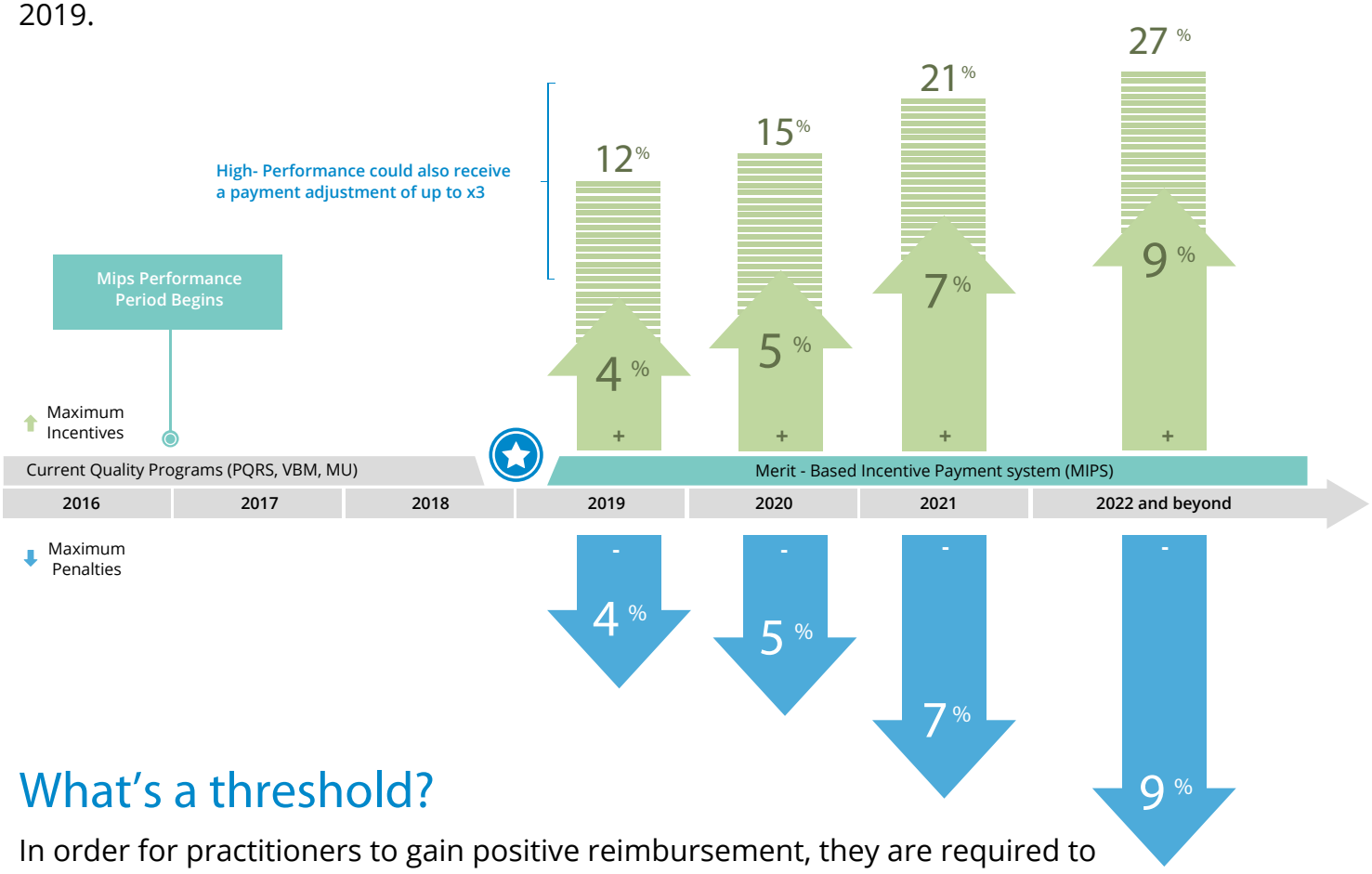
There are two measures for each category and the score will be awarded if you satisfy the minimum requirements for each measure. The measures include:

- Medicare Spending per Beneficiary- a minimum of 35 cases
- Total Per Capita Cost for all attributed beneficiaries- a minimum of 20 cases.
- Both measures should be satisfied in order to get maximum 10% weight in this category.

The Payment Adjustment Process

As mentioned before that the payment adjustment process with respect to the performance information reported in 2017 will initiate in 2019 based on their MIPS Final Score. Now for the practitioners who had been vigilant of this act from the start would either receive a positive or neutral reimbursement in 2019. On the other hand, the practitioners who failed to do so would get a negative reimbursement.

In addition to that, the positive and negative reimbursement ratio would increase gradually for three years according to the CMS. In addition to that, the payment adjustment process would occur in the second year after the reporting period. For instance, the practitioners who were ignorant towards MIPS in 2017 would have a negative payment adjustment of 4% in 2019.



What's a threshold?

In order for practitioners to gain positive reimbursement, they are required to lie above the threshold. The question that confuses most practitioners is that what is a threshold and how can we lie above it? The answer's quite simple, the threshold is the minimum magnitude of qualitative performance required from the practitioners. This threshold will be revised every year by the CMS and the individual performance of the clinics will be compared to identify which of the clinics would gain appositive reimbursement and which would gain a negative reimbursement.

Based on the threshold, the reimbursement of the clinics would be divided into four categories.

Neutral Payment Adjustment: Clinics who would lie on the threshold would have a neutral payment adjustment within their accounts.

Downward or Negative Payment Adjustment: Clinics who would lie below the threshold would incur a negative payment adjustment within their accounts. However, the degree of the negative payment adjustment may vary from clinic to clinic based on their MIPS Final Score.

Upwards or Positive Payment Adjustment: The Eligible Clinics who would lie above the threshold would benefit from their positive payment reimbursement process into their accounts. Similarly, the degree of the positive payment adjustment may also vary from clinic to clinic based on their MIPS Final Score.

Exceptional Performance Bonus: As mentioned earlier, that the purpose of this strategy is to promote a qualitative approach while dealing with the patients and to promote just that, the clinics that would perform exceptionally well would gain an Exceptional Performance Bonus. Top 25% of the clinics that would lie above the threshold would be eligible for the Exceptional Bonus up to 10% along with their normal positive payment adjustment of 9% in 2022 as shown in the diagram above.

MIPS maximum payment adjustment range:

Performance Year	Adjustment Year	Maximum Penalty (%)	Maximum Incentive (%)	Maximum Exceptional Bonus (%)
2017	2019	-4%	+4%*X	+10%*Y
2018	2020	-5%	+5%*X	+10%*Y
2019	2021	-7%	+7%*X	+10%*Y
2020	2022	-9%	+9%*X	+10%*Y
2021	2023	-9%	+9%*X	+10%*Y

The maximum penalty charged ranges from -4% to -9% over a period of four years. Moreover, the maximum incentive for the practitioners would be the sum of the basic incentive and the exceptional bonus earned.

An interesting factor for the practitioners is that in both of the incentives depend on the scalable factors X and Y.

CMS calculates the value of X which is the budget neutrality factor in such a way that the national base incentive budget is equal to the national penalty budget. Therefore, the practitioners earning the incentives are being paid by the penalized practitioners based on their performance.

As for the value of Y, CMS allocates a budget of $500M annually for the ECs who show an exceptionally good performance

How to get a good score?

As a practitioner, you would definitely want to get a good MIPS Final Score and in order to do so, the following five steps should be kept in mind.

Scores, not Time Frame: The final score weighs more than the reporting time frame, so the primary focus should also be on improving the final score. The main advantage of choosing a full year time frame includes more diversified measures of performance to choose from. Moreover, through these diversified measures practitioners can choose measures in which they can get a higher score and along with that also increase their chances of getting bonus points.

Choose Painless Measures: In order to get maximum scores, practitioners should choose measures that do not require 100% effort so that they can easily gain full 10 points. These measures are also called 'topped out measures' in some cases for the reason that it is quite easy to get a good score in them.

High-Priority Measure: Make sure you choose at least one of the high-priority measure or an outcome measure which is required for the eligibility for the maximum payment adjustment.

Choosing the Time Frame: While making a decision regarding the time frame, it's better to choose a time frame which offers the maximum measures to choose from. Since each measure comes with its own benchmark it would be easier to report the measures which are easy to handle for the Eligible Clinicians.

Aim for the Bonus: In the Quality category, there are two bonus points for each additional outcome and patient experience measure and one bonus point for each additional high-priority measure. The combined total of maximum bonus points for reporting these extra measures is 6 points. Also, by using a Certified Electronic Health Record Technology (CEHRT) to report electronically, you will receive an additional one bonus point per measure.

Aim for the Bonus: In the Quality category, there are two bonus points for each additional outcome and patient experience measure and one bonus point for each additional high-priority measure. The combined total of maximum bonus points for reporting these extra measures is 6 points. Also, by using a Certified Electronic Health Record Technology (CEHRT) to report electronically, you will receive an additional one bonus point per measure.

How to make the right choice for your EHR?

The right choice will be the one with 100% success records in PQRS and Meaningful Use. Choose an EMR with these features:

Proactive Approach: A dedicated MIPS consultation team can assist you in reviewing and analyzing your clinician performance. Not only this but proper training, education, and support also plays an imperative role in the end.

Seamless Integration: Quality Payment Program needs to be integrated into a clinical workflow for easy compliance and evasion of penalties.

Comprehensive Support: Choose an EMR that supports you in the entire program cycle from enrollment to attestation. It supports you in making the right quality measure choice along with its reporting requirements, user training, data collection, progress review, and attestation. Such a choice would ensure your success.

Experience: A legitimate EMR choice would be the one with the years of experience in consulting and training clinicians to meet the quality program guidelines and comply with CMS audits.

Reporting: Choose the one which enables you to focus on the quality care output and their MIPS consulting team reports on your behalf. This will help you to focus on the patients and your EMR handles all the other stuff.

Physician's feedback: Looking into the reviews of the clinicians regarding EMR would help you in making the right choice.