October 2 Is Almost Here: Are You MIPS-Ready?

written by Dave Halpert | September 7, 2017



Calendar check! October 2, the last chance to start your continuous 90-day participation in MIPS, is nearly here. Those who meet minimum standards in the “Pick Your Pace” transition year will avoid a whopping 4 percent penalty on their 2019 Medicare Part B reimbursements. Those who exceed these requirements and perform strongly in MIPS stand to earn

incentive payments on top of the regular reimbursement schedule.

To make sure that you're among those who will earn incentives (or at least avoid penalties), take an opportunity to review MIPS requirements, assess what's in place and close the remaining gaps.

What Do You Need to Report?

There are four components in MIPS, but in 2017, only three will be used to calculate your MIPS composite score. The pieces (and contributions to the MIPS score) are:

- Quality (60 percent)
- Improvement Activities (15 percent)
- Advancing Care Information (25 percent)
- Cost (Not weighted; feedback will be for informational purposes)

Certain components may be re-weighted when calculating your final score. This will depend on participation in other programs, the type of care provided or the setting in which care is delivered.

Group Practice and Individual Reporting

Providers may choose to report as individuals, or as a Group Practice.

If you are reporting as an individual, you are defined by CMS as the combination of your individual NPI and Practice Tax Identification Number (TIN). Your 2017 MIPS score and 2019

payment adjustment will be applied to anything billed under that combination of numbers. Each requirement is your responsibility.

If your practice reports as a group, you will be scored at the TIN level, meaning that everyone bills under the TIN is scored together, in one composite score. Some providers will play a larger role than others, but in the end, it's a team effort. If someone in the practice performed an Improvement Activity, the entire practice earns credit. However, this also means that if a practice is submitting a quality metric, that measure's numerator and denominator must incorporate data from all charges under that TIN.

In prior posts, we've recommended Group Practice Reporting over individual reporting. The Group Practice Reporting Option (GPRO) is easier to administer, is patient-centric and can help you narrow your external focus. Partnering with a QCDR that can help you report as a group while maintaining individual accountability is the best of both worlds.

Luckily, there's no sign-up required this year to report as a Group Practice, if you're reporting through a QCDR, Qualified Registry or EHR.

Quality

The Quality component of MIPS is scored according to your performance in quality reporting. This is the new look for what was formerly PQRS and a portion of the Value-Based Payment Modifier. The full reporting requirements are that an individual or group practice (reporting through a Registry, QCDR, or an EHR) must report on at least six different

measures, and at least one of those must be an outcome measure. If no outcome measures apply, CMS has instructed that another "high-priority" measure is allowed.

To earn maximum points for a measure, participants must provide data on at least 50 percent of the eligible patients. Points are awarded for each measure according to performance thresholds calculated by CMS. A measure can be worth up to 10 points, or as little as 3 points. The latter will occur if a measure has not been reported to the required 50 percent, if performance is poor or if CMS has not benchmarked the measure.

With so many measures missing benchmarks or being "topped out" (performance points are capped by CMS), you should make sure that you have as many reporting options as you can. Avoid finding yourself pinned down to a small set of measures that are "performance prohibitive" by partnering with an ONC-Health IT Certified QCDR.

Improvement Activities

The purpose of Improvement Activities is to demonstrate that your group has actively gone beyond quality reporting or utilizing Health Information Technology, making additional efforts to improve patient care. Improvement Activities are new for MIPS—they weren't scored under a previous program.

To earn the full 15 percent for your MIPS composite, you must complete between two and four Improvement Activities for a minimum of 90 days. Activities are classified as "medium" and "high," with the former being worth 10 points, and the latter worth 20. If you are in a group with 15 or more providers, your goal is to earn 40 points (e.g. four "medium" activities, two

“high” activities, or a combination). Groups with fewer than 15 participants only need 20 points to earn the full 15 percent for their MIPS score (one high-weighted activity or two medium-weighted activities).

Providers who are engaged in MIPS APMs or who are in accredited Patient-Centered Medical Homes (PCMH) may be exempted from having to attest for additional activities. One of the goals of the Quality Payment Program (specifically MIPS) is to reduce duplicative efforts needed to satisfy multiple programs. In other words, if you are in a PCMH, you have already demonstrated that you’ve performed several of the Improvement Activities, over a longer period than 90 days.

Remember, Improvement Activities are attestation-based, and you must only answer that you did the activity. If it wasn’t successful (i.e. outcomes did not improve), you will not be penalized. For that reason, these activities are an ideal opportunity to pilot a new program. Even if your results aren’t what you’d hoped, you’re still earning credit for the program and can learn from your experience. Knowing that something did not work is valuable information and can provide insight for future programs. If your efforts are successful on the first try and you’re able to improve outcomes or reduce costs, so much the better. You’ll see impact in future quality and cost measurements and, more importantly, in your patients. Here’s a novel idea: look at specific areas where you’ve come up short in the past and develop an IA strategy that facilitates meaningful improvement.

Advancing Care Information

Meaningful Use has been repackaged into MIPS, constituting the

Advancing Care Information (ACI) category. Like Improvement Activities, these results are also calculated through attestation, but performance will factor into your ACI score.

Depending on your EHR version, you can attest (either with a yes/no or with numerator and denominator results) to performing specific tasks using certified EHR technology. Whether you use the ACI measures (advanced ONC Certification required) or the ACI Transition measures (for those whose systems are certified to the 2014 edition), credit is earned by achieving a base score, worth half of the ACI score, and then by earning a performance score to make up the rest. However, participants must earn that base score to earn anything in the ACI category. Without the base score, ACI will be zero, regardless of how many performance or bonus points were earned.

Some providers, notably hospital-based clinicians, may be automatically exempted from this category. The 25 percent is reassigned to the Quality score. Therefore, these providers should be especially cognizant of their quality score, as it will be worth 85 percent of their total MIPS composite score.

Is It Too Late? Not with a QCDR

One of the most important benefits of reporting through a Registry or a QCDR is that it is not too late to start. However, as we approach the Fourth Quarter, remember that, just like football, there will be a point where it’s too late to stage your comeback.

Since Quality will account for most of your MIPS composite, let’s start there. Advanced Registries with the technology to retrospectively collect and process data can still glean a full

year's worth of results, even if we're starting later in the year. In other words, even if you don't have an agreement in place until after October 2, it is still possible to create a comprehensive Registry and submit a full year's worth of data.

Improvement Activities and Advancing Care Information are less forgiving, but still feasible. Each must be continuously performed/calculated over 90 days, so if you have not started before October 2, a Registry cannot help. However, if you have been performing these activities and tasks (but have not engaged a Registry quite yet), you're still in the game. Certain QCDRs and Qualified Registries can submit the final results on your behalf, even though they've not been involved with the process.

The future of MIPS is uncertain, but it most assuredly is the rule of the day. As October 2 looms, do your practice's short-term bottom line a favor, and hustle to get your strategy in place, if you haven't already done so. Do your practice's long-term bottom line and, more importantly, your patients a favor by creating a strategy that avoids "hoop jumping." Build your strategy on improvement, focusing on outcomes and costs over time. By maximizing performance, you'll optimize success in any quality initiative, and will do so by making your patients healthier.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

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