MIPS Action Plan: 10 Key Steps for 2018

The basics

Year 2 of the Medicare Quality Payment Program (QPP) began on January 1, 2018 and requires that eligible physicians and certain non-physician practitioners participate in either the Merit-Based Incentive Payment System (MIPS) or in an advanced Alternative Payment Model (APM). MIPS-eligible clinicians that do not participate in either track in 2018 will receive a **5% penalty** applied to their 2020 Medicare reimbursement. More information is available at the AMA's Understanding Medicare Payment Reform site.

How to use the Plan

This Action Plan is intended for physicians who plan to participate in MIPS and who are not participating in an advanced APM.

The Action Plan steps are to assist you in planning your approach to MIPS participation. For more detailed information, refer to the AMA's 2018 MIPS Strategic Scoring Guide and other AMA resources on Quality Payment Program Specifics. You can also use the AMA Payment Model Evaluator tool for a personalized assessment of the financial impact on your practice.

Keep in mind that completion of certain steps may or may not be applicable, depending on your level of MIPS participation.

Step 1	☐ Determine whether MIPS Applies to You
Step 2	☐ Review Available Performance Categories
Step 3	☐ Plan Your MIPS Participation
Step 4	☐ Review your Data
Step 5	☐ Decide whether to Report as an Individual or a Group
Step 6	☐ Choose your Quality Reporting Mechanism
Step 7	☐ Perform a Security Risk Analysis
Step 8	☐ Report for at Least 90 Days (ACI/IA) **CMS DEADLINE: Oct. 1, 2018** **AND/OR** ☐ Report for a calendar year (Quality) **CMS DEADLINE: Jan. 1, 2018**
Step 9	☐ Complete MIPS performance **CMS DEADLINE: DEC. 31, 2018**
Step 10	☐ Submit 2018 MIPS Data

*May or may not be applicable, depending on your level of MIPS participation.

Reminder: You can avoid a 5% penalty on your 2020 Medicare reimbursement in several ways, including by reporting sufficient information in any one MIPS component in 2018. See the below guidance regarding the MIPS Limited Participation option for more details.

Step 1: Determine whether MIPS Applies to You

If you provide care for Medicare patients, you may be required to participate in MIPS to avoid application of a penalty to your Medicare payments in 2020. Many but not all clinicians who participate in Medicare Part B, including physicians and some non-physician practitioners (such as Nurse Practitioners and Physician Assistants), are MIPS-eligible clinicians.

If you meet the below exclusion criteria, you are not MIPS-eligible:

- You are newly enrolled in Medicare in 2018; or
- You see 200 or fewer Medicare Part B patients per year; or
- You submit less than or equal to $90,000 allowed Medicare Part B charges annually; or
- You are on the participant list on at least one of 3 snapshot dates (3/31, 6/30, or 8/31) for a model that CMS has deemed an Advanced Alternative Payment Model (AAPM) for purposes of QPP participation. See the Centers for Medicare & Medicaid Services (CMS) list of AAPMs.

CMS will send out correspondence to all individuals or groups with a Taxpayer Identification Number (TIN) enrolled in Medicare to communicate whether an individual or group is MIPS-eligible. If you are unsure whether you are MIPS eligible or exempt, you can check your status through CMS' MIPS-eligibility look up tool.

Note that if you qualify as MIPS-eligible, participation in the program in 2018 is required to avoid a 5% penalty on your 2020 Medicare reimbursement.

Step 2: Review Available Performance Categories

In 2018, MIPS will count your performance in up to four categories. Review the performance categories and identify which categories will have measures that are applicable to your practice. You can also check the AMA's 2018 MIPS Strategic Scoring Guide to help plan your strategy.

The categories are:

- **Quality**—In this category, an individual or group reports quality data on clinician-selected measures. This category is the replacement for CMS' Physician Quality Reporting System (PQRS) and makes available over 450 Quality measures to choose from (for example, providing receipt of specialist report or documentation of current medications in the medical record). Additional measures are also available if you decide to participate in MIPS via a Quality Clinical Data Registry (QCDR). Many but not all of the 2018 CMS designated QCDRs are sponsored by specialty societies. Eligible-clinicians (EC) participating as a group consisting of 16 or more ECs may also be scored on a CMS administered and calculated All-Cause Hospital Readmission measure.
- **Advancing Care Information (ACI)**—In this category, an individual or group attests to performance on certain Electronic Health Record (EHR) measures. ACI is the replacement for the CMS' EHR Incentive Program (Meaningful Use) and requires use of Certified Electronic Health Technology (CEHRT). You can use either the 2014 or 2015 Edition of CEHRT in 2018, but you will receive MIPS bonus points if you use an EHR that meets the 2015 Edition of the certification criteria. Note that eligible clinicians must use 2015 Edition CEHRT in 2019, so 2018 is a good time to think about your transition to new software.
- **Improvement Activities (IA)**—In this category, an individual eligible clinician or group attests to performance on certain CMS-designated improvement activities (for example, annual registration in a Prescription Drug Monitoring Program or improvements to care transitions in the 30 days following patient discharge).
- **Cost**—In 2018, CMS will use claims data to determine the cost of the care eligible clinicians provided to their Medicare patients and use that information to calculate their MIPS score. CMS will use two measures to assess the Medicare Part A and B allowed charges associated with certain patients and hospital admissions. Because CMS will calculate this information based on claims submitted to Medicare, eligible clinicians do not need to submit any additional data on Cost. For more information on this category, see the AMA's Cost Category resource.

Step 3: Plan Your MIPS Participation

For 2018, CMS discontinued the 2017 "Pick Your Pace" transitional option. Therefore, if MIPS applies to you, it is no longer sufficient to report a single quality measure to avoid a penalty. CMS will determine your 2018 participation level based on the data that you submit.

Limited Participation—Because 2018 is another transition year, CMS still allows a flexible option that we refer to as a "Limited Participation Track." Under this track, you can still avoid application of a payment penalty in 2020 for performance in 2018 by achieving a MIPS "Total Score" of **at least 15 points**. There are multiple ways to achieve 15 points; some of these include:

- Participating in **any one of** the Quality or IA, or ACI tracks; see the AMA's Strategic Scoring Guide;
- Reporting the ACI "Base" measures and two Quality measures (or one Quality measure if you are a small practice).

Full Participation—To avoid a 5% penalty in 2020 **and** potentially receive a positive payment adjustment, or be eligible for a share of the $500M bonus pool for exceptional performers, you need to report:

- A **full year of data** for 6 Quality measures, including one outcome measure; and
- A combination of high- and medium-weight IA measures for at least 90 days (exact number will vary based on practice size and rural or non-rural location); and
- Base score ACI measures plus any additional performance or bonus measures for at least 90 days.

In addition to the data you report, remember that CMS will also automatically calculate a Cost score based on your claims data. Your final score will depend on a combination of your reported data and this CMS-generated Cost score. For more information on the Cost category, see the AMA's Cost Category FAQ.

Step 4: Review your data

To better understand how you may perform in the MIPS program and tailor your participation in 2018, review your past performance in other Medicare quality programs, such as PQRS, the EHR Incentive Program (Meaningful Use), and the Value Based Modifier (VBM). You can use your September 2017 Quality Resource Use Report (QRUR) or your 2016 PQRS Feedback Report (which became available in late 2017) to help gauge future performance. These reports include tables that detail performance by group and individual, and can help you understand how you've done in the past, how you might do in the future and opportunities for improvement. For quality reporting, if you would like to earn an incentive, you should also review the 2018 quality measure benchmarks.

You'll need an account with CMS' Enterprise Identity Management (EIDM) system to view your QRUR, which may take time to initiate or reactivate. This is the time to make sure that your practice has a registered account and the properly designated "role" to access these reports. Contact the CMS help desk for assistance.

Step 5: Decide whether to Report as an Individual or a Group

You can submit MIPS data as an individual or as a group under the group practice reporting option (GPRO). If reporting under GPRO, analysis is performed at the Taxpayer Identification Number (TIN) level. The decision to report as an individual or a group is both an administrative and a strategic one. For example, under GPRO all members of the group must use the same measures and penalties or incentives will be applied to the group as a whole. If you are reporting as a group and consists of 16 or more eligible clinicians the CMS administered All-Cause Hospital Readmission measure may apply to you. Keep in mind, if you are an eligible clinician who is part of a group, your group does not have to report under GPRO— the group still has the option of having its eligible clinicians report as individuals.

Eligible clinicians or practices that operate under multiple TINs must successfully participate in MIPS for each NPI/TIN combination in order to avoid a penalty.

In order to submit data as a group, your Electronic Health Record (EHR) or registry must be able to receive your data and support your data submission under the group option. Groups of at least 25 eligible clinicians have the additional option of reporting through the CMS Web Interface. There is no need to re-register if your group previously used the Web Interface, but if your group is using it for the first time in 2018 you must register to do so by June 30, 2018.

If your group decides to report on IA, only one eligible clinician need perform the IA for the whole group to receive credit.

Step 6: Choose your Reporting Mechanism

There are a number of mechanisms available for MIPS reporting:

- **Qualified Registries**—These entities collect and submit clinical data on patients to CMS, regardless of payor, on behalf of clinicians. You can see a list of Qualified Registries for 2018 here.
- **Qualified Clinical Data Registries (QCDRs)**—Like qualified registries, CMS approves these entities for tracking disease and patient data. QCDRs report on patients seen through all payors and are not limited to measures within the current PQRS system. QCDRs often include specialty-specific measures. Check with your specialty society about whether it supports a QCDR and listen to the AMA-ReachMD podcast on QCDRs. The 2018 list of CMS-designated QCDRs and QCDR measures can be found here.
- **CMS Web Interface**—This option is only available for groups of 25 or more eligible clinicians who can report 12 months of Quality measure data. During the submission period, the web-interface now allows you to check your MIPS Quality score, model potential scores based on different Quality measures, and identify missing data. Groups using the Web Interface for the first time must register with CMS by June 30, 2018.
- **EHR**—When considering whether to use an EHR for reporting, ask your vendor about dashboard functionality (which may help you track performance), whether the EHR is federally certified and to what set of criteria (2014 or 2015), if the available electronic quality measures are applicable to your practice, anti-data blocking attestation, and compliance with privacy and security requirements. If reporting under the GPRO, ask your EHR vendor whether they support GPRO reporting or only individual reporting.
- **Claims-based reporting**—This is reporting using codes on Medicare claims and is available for individual physician quality reporting only.

All of the above mechanisms are available for Quality reporting; ACI and IA reporting are available only through a Qualified Registry, QCDR, EHR, or qpp.cms.gov.

When contacting a vendor or registry, ask what capabilities it has for MIPS reporting and confirm that your selected reporting mechanism will be able to report on the performance measures that you have chosen.

Step 7: Perform or Review a Security Risk Analysis

If you are reporting on the ACI category, you must perform or review a Security Risk Analysis applicable to 2018 to avoid an overall score of zero in that category. Note, however, that entities that create, receive, maintain, or transmit electronic protected health information (ePHI) must complete a Security Risk Analysis under HIPAA regardless of whether they participate in ACI. Allocate time to address any deficiencies to ensure that you can successfully attest. The AMA has resources on the HIPAA Security Rule & Risk Analysis to help you complete the analysis.

Step 8: Report for at Least 90 Days (If Reporting ACI or IA)

CMS DEADLINE TO BEGIN COLLECTING DATA: OCT. 1, 2018 (for ACI or IA)

AND/OR

Report for a calendar year (If Reporting Quality)

CMS DEADLINE TO BEGIN COLLECTING DATA: JAN. 1, 2018 (for Quality)

You can successfully participate in the Limited Participation track and avoid the 5% penalty by meeting all of the requirements for a single reporting category (Quality, ACI, or IA), or by reporting a combination of measures in different categories as long as they meet the 15 point minimum threshold.

If you plan to only report on ACI or IA measures, a minimum participation period of 90 days is required, which means that you must begin participating in those activities no later than October 1, 2018.

Unlike in 2017, this 90-day period does not apply to Quality measures. If you plan to report on Quality measures, you must report data covering the full year. Small practices may have other options to reach 15 points and avoid a penalty, see the AMA's Strategic Scoring Guide. However, note that some vendors may help you retrospectively collect a full year's worth of Quality data even if you start working with them later in the year.

Step 9: Complete MIPS Performance

CMS DEADLINE: DEC 31, 2018

Make sure that you have met the data completeness criteria for your selected Quality measures and to meet ACI and IA requirements, as required by your chosen participation track. If you don't have all of the required data under the Full Participation track, be sure to report on a sufficient number of Quality, ACI, and/or IA measures to reach 15 points and successfully avoid the 5% penalty on your 2020 Medicare reimbursement.

Step10: Submit 2018 MIPS Data

You should check with your chosen reporting vendor or on the CMS website to understand the due date for reporting MIPS data that applies to you. Submission due dates will vary by reporting mechanism: for example, the submission deadline is March 1, 2019 for those using the claims reporting option to report quality measures. If you are using the CMS Web Interface, the submission period will occur during an 8-week period (following the close of the 2018 performance period) that will begin no earlier than January 1 and end no later than March 31 (specific start and end dates will be published on the CMS Web site). Also, your vendor may have its own deadlines. Closer to the end of the reporting period, you should check the CMS QPP website (www.qpp.cms.gov) to identify the precise deadlines that apply to your data reporting mechanism in 2019.

CMS has added significant capability to its data submission site starting in 2017. The new site allows you to see performance data for each measure, your predicted score, and certain missing or incomplete information. If you submit data via claims or through the CMS Web Interface, it will allow you to see beneficiary-level information about data completion and performance for each measure you report. It will also allow you to verify data submitted by vendors on your behalf. As a result, even if you are not submitting data in 2017, you should review the site to prepare for 2018.

Once CMS receives this data it will have the information it needs to calculate your 2018 performance score for the purposes of determining your 2020 Medicare reimbursement level (ideally avoiding a 5% penalty, potentially receiving a modest upward payment adjustment and/or qualifying for a share of the exceptional performance pool). CMS has stated it will notify you of your score in a MIPS feedback report in the fall of 2019, but will attempt to provide even more timely feedback.

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