MIPS Action Plan: 10 Key Steps for 2019

The Basics

Year 3 of the Medicare Quality Payment Program (QPP) began on January 1, 2019 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 who do not participate in either track in 2019 will receive a 7% penalty applied to their 2021 Medicare Part B reimbursement. More information is available at the AMA's Understanding Medicare Payment Reform site.

How to use this Plan

This Action Plan is intended for clinicians who plan to participate in MIPS and who are not participating in an APM. The Action Plan steps are designed to assist you in planning your approach to MIPS participation. Keep in mind that completion of certain steps may or may not be applicable, depending on your level of MIPS participation. For more detailed information, please refer to the AMA's 2019 MIPS Strategic Scoring Guide and other AMA resources on Quality Payment Program specifics.

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 2021. Many but not all clinicians who participate in Medicare Part B, including physicians and some non-physician practitioners, are MIPS-eligible clinicians.

If you meet one of the below exclusion criteria, you are not required to participate in MIPS:
* You are newly enrolled in Medicare in 2019; or
* You meet one of the low-volume threshold criteria, defined as:
    1. You see 200 or fewer Medicare Part B patients per year; or
    2. You submit less than or equal to $90,000 allowed Medicare Part B charges annually; or
    3. New: You provide 200 or fewer covered professional services under the Physician Fee Schedule per year.
* 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 (APM) for purposes of QPP participation. See the Centers for Medicare & Medicaid Services (CMS) list of APMs.

New: Clinicians and groups are able to opt in to MIPS if they meet or exceed one or two, but not all, of the low-volume threshold criteria. Once the clinician or group elects to opt-in to MIPS, the decision is irrevocable and cannot be changed for the 2019 performance period.

Clinicians who are unsure if they are MIPS-eligible or exempt should log in to the CMS QPP Participation Status

tool to determine whether MIPS participation is required in 2019.   If you qualify as MIPS-eligible, participation in the program in 2019 is required to avoid a 7% penalty on your 2021 Medicare reimbursement.

New: The following clinician types (and groups composed of these clinicians) are now included in the definition of a MIPS-eligible clinician, meaning that MIPS participation is required unless one or more of the preceding exclusion criteria are met:
- Physical therapist
- Occupational therapist
- Qualified speech-language pathologist
- Qualified audiologist
- Clinical psychologist
- Registered dietitian or nutrition professionals

Step 2: Review Available Performance Categories

In 2019, MIPS will calculate your performance in up to four categories, each weighted separately in the calculation of the overall MIPS Score. Review the performance categories and identify which categories have measures that are applicable to your practice. You can also check the AMA's 2019 MIPS Strategic Scoring Guide to help plan your strategy.

The categories are:
- **Quality**—The Quality category accounts for 45 percent of your MIPS Score. In this category, an individual or group reports quality data on clinician-selected measures. For 2019, CMS added 8 new quality measures and removed 26 measures. Additional measures may be available if you decide to participate in MIPS via a Qualified Clinical Data Registry (QCDR). Many but not all of the 2019 CMS-designated QCDRs are sponsored by specialty societies. MIPS-eligible clinicians participating as a group consisting of 16 or more eligible clinicians that meet the case minimum will also be scored on a CMS-administered and calculated All-Cause Hospital Readmission measure.

  New: Medicare Part B claims measures can only be used by clinicians in small practices (15 or fewer eligible clinicians), whether participating individually or as a group, to fulfill the reporting requirements for the Quality category.

  New: Physicians submitting eCQMs must use 2015 Edition Certified Electronic Health Record Technology (CEHRT). Electronic Health Record (EHR) technology will need to be certified to the 2015 Edition by the last day of the Quality performance period (December 31, 2019).

- **Promoting Interoperability (PI)**—The PI category accounts for 25 percent of your MIPS Score. This category was previously titled Advancing Care Information (ACI). In this category, an individual or group attests to performance on certain EHR measures. Performance is based on reporting that aligns with four objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange. Clinicians and groups are required to report certain measures from each of the four objectives, unless an exclusion is claimed. Clinicians and groups that do not meet the required measurement volumes for certain measures may claim an exclusion for those measures, in which case the weight of those measures is reassigned to other measures.

  New: MIPS-eligible clinicians and groups must use 2015 Edition CEHRT in order to satisfy the PI criteria requirements.

- **Improvement Activities (IA)**—The IA category accounts for 15 percent of your MIPS Score. In this category, an 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). For 2019, CMS added 6 new IAs, modified 5 existing IAs, and removed 1 IA.

- **Cost**—The Cost category accounts for 15 percent of your MIPS Score. In 2019, CMS will continue to 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. 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.

  New: CMS will now use up to 10 measures to assess the Medicare Part A and B allowed charges associated with certain patients and hospital admissions. These include the two measures used previously—Total Per Capita Cost and Medicare Spending Per Beneficiary—as well as 8 new episode-based measures related to care for a particular clinical condition or procedure.

Step 3: Plan Your MIPS Participation

CMS will determine your 2019 participation level based on the data that you submit. See table below depicting impact of MIPS scores on Part B reimbursement in 2021.

Limited Participation—MIPS-eligible clinicians and groups can avoid a payment penalty in 2021 for performance in 2019 by achieving a MIPS "Final Score" of **at least 30 points**.

Full Participation—To avoid a 7% penalty in 2021 **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
- Report PI measures for at least 90 days.

In addition to the data you report, 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 2019, start by reviewing your past performance in MIPS. 2017 data is now available and 2018 data will be available shortly at the same site. If you have not previously participated in MIPS and the scope of your practice has not significantly changed in recent years, it may be useful to review your performance in other Medicare quality programs, such as PQRS, the EHR Incentive Program (Meaningful Use), and the Value Based Modifier (VBM) to help gauge performance in MIPS in 2019. For example, a review of your September 2017 Quality Resource Use Report (QRUR) or your 2016 PQRS Feedback Report may be useful in providing information   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 on your 2021 Part B payment, you should also review the 2019 MIPS Quality measure benchmarks.

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 any penalties or incentives will be applied to the group as a whole. If you are reporting as a group 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 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; if your group is using it for the first time in 2019 you must register to do so between April 1 - June 30, 2019.

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

New: The Web Interface measures cannot be scored with other collection types other than the CMS-approved survey vendor measure for CAHPS for MIPS an administrative claims measures. The CMS Web Interface also cannot be used by groups to submit data for the IA and PI performance categories.

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 2019 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 2019 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. The CMS Web Interface cannot be used to submit data for the IA and PI performance categories.
- **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 (2015 Edition CEHRT is required for reporting PI in 2019), if the available electronic quality measures are applicable to your practice, anti-data blocking attestation is supported, and compliance with privacy and security requirements is assured. 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 individuals in a small practice (15 or fewer eligible clinicians) reporting individually or as a group.

New: Individual clinicians and groups may use multiple collection mechanisms for reporting under the Quality category. If the same measure is submitted via multiple collection types, the one with the greatest number of measure points will be selected for scoring.

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 PI category, you must perform or review a Security Risk Analysis. For 2019, this measure will not be calculated as part of the overall PI score, but it is still required. Clinicians and groups must attest that they completed the actions included in the Security Risk Analysis measure at some point during the 2019 calendar year, and those who fail to complete these actions or fail to attest will earn a zero in the PI performance category, regardless of whether they report on other measures for this category. Note 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 report in the PI category. 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 PI or IA)

CMS DEADLINE TO BEGIN COLLECTING DATA: OCT. 1, 2019 (for PI or IA)

AND/OR

Report for a calendar year (If Reporting Quality)

CMS DEADLINE TO BEGIN COLLECTING DATA: JAN. 1, 2019 (for Quality)

You can participate in MIPS and avoid the 7% penalty by reporting in two categories (Quality, PI, or IA), or by reporting a combination of measures in different categories as long as they meet the 30 point minimum threshold.

If you plan to only report on PI 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, 2019.

If you plan to report on Quality measures, you must report data covering the full year. Small practices may have other options to reach 30 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, 2019

Make sure that you have met the data completeness criteria for your selected Quality measures and to meet PI 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, PI, and/or IA measures to reach 30 points and successfully avoid the 7% penalty on your 2021 Medicare reimbursement.

Step10: Submit 2019 MIPS Data

You should check with your chosen reporting vendor or on the CMS website to confirm 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, 2020 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 2019 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 website). Also, your vendor may have its own deadlines. Closer to the end of the reporting period, you should check the CMS QPP site to identify the precise deadlines that apply to your data reporting mechanism in 2019.

CMS has added significant capability to its data submission site since Year 1 of the QPP in 2017. The 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.