2019 MIPS Strategic Scoring Guide

Year 3 of the Medicare Incentive Payment System (MIPS) under the CMS Quality Payment Program (QPP) began on January 1, 2019 and directly impacts Medicare Part B clinician reimbursement for covered professional services (but not Part B drugs and other items) in 2021 by up to +/- 7 percent. Some MIPS-eligible clinicians may receive exemptions from certain portions of the program or be eligible for bonus points based on their practice type. The information below is designed to help you formulate your 2019 MIPS strategy.

Changes to the Definition of MIPS-Eligible Clinician

The Centers for Medicare & Medicaid Services (CMS) has expanded the scope of clinicians eligible to participate in MIPS in 2019. Previously, participation was limited to physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include these clinicians. Starting in 2019, the definition of MIPS-eligible clinician now includes physical therapists, occupational therapists, qualified speech-language pathologists; qualified audiologists, clinical psychologists, registered dieticians, nutrition professionals, and groups of clinicians previously included in this definition.

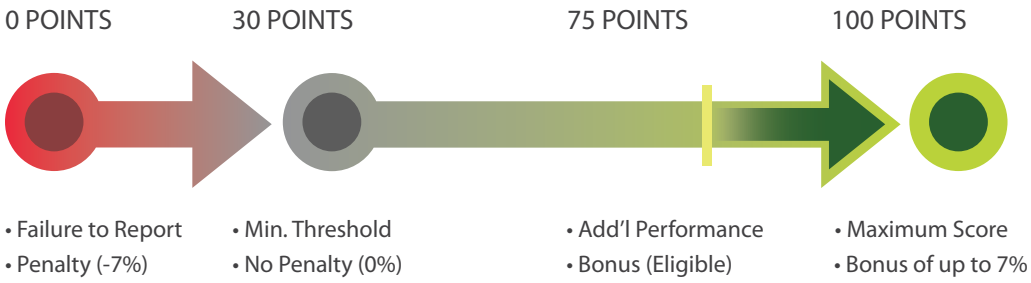
This change means that clinicians and groups that were previously exempted from MIPS participation may be required to participate in 2019. For example, multi-specialty groups comprised of clinicians that were not required to participate in MIPS should evaluate how the inclusion of such clinicians will impact the groups' performance on MIPS Scoring.

Individuals belonging to one of the newly included clinician types should utilize the Quality Payment Program portal eligibility determination tool to determine their MIPS eligibility status, ideally prior to the start of the 2019 performance period.

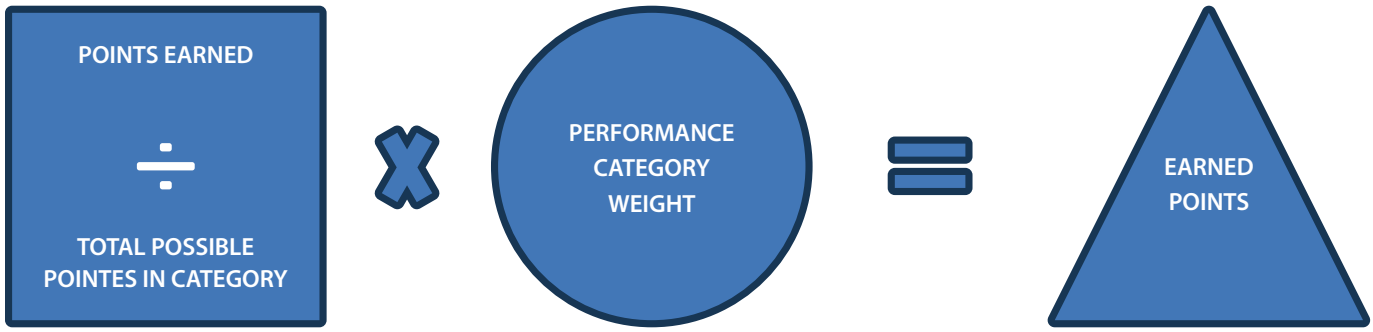
CMS expanded the exclusion criteria for 2019 to include one of the following: (1) furnishing less than or equal to $90,000 in Medicare Part B covered professional services; (2) furnishing covered professional services to 200 or fewer Medicare beneficiaries; (3) or furnishing 200 or fewer covered professional services. Clinicians and groups that meet or exceed at least one of these criteria will be excluded from MIPS unless they affirmatively opt in. For 2019 CMS finalized an opt-in policy that allows eligible clinicians to opt-in to MIPS if the eligible clinician or group meets or exceeds at least one, but not all, of the low-volume threshold criteria. Therefore, such clinicians and groups should evaluate whether they are eligible to opt-in to MIPS and whether it may be advantageous to do so. It is important to know that once a decision to opt-in is communicated to CMS, it cannot be reversed.

Understanding MIPS Scoring

CMS calculates a MIPS final score of 0 – 100 points for each MIPS-eligible clinician or group. Starting in 2019, MIPS-eligible clinicians and groups must achieve at least 30 points to avoid a reimbursement penalty of 7 percent, and at least 75 points to be eligible for a positive reimbursement adjustment. The below graphic shows key markers related to potential payment adjustments:



Your MIPS score is based on performance in four categories: 1) Quality (45%); 2) Promoting Interoperability (PI) (25%); 3) Improvement Activities (IA) (15%); and 4) Cost (15%). Some reweighting of the categories based on practice type is discussed below. CMS uses the following formula within each category to determine points earned:



There are a variety of ways to meet the 30 point threshold to avoid a penalty applied to your 2021 reimbursement. CMS has also outlined ways for you to score higher and become eligible for positive payment adjustments. As discussed below, you may be eligible for "special scoring" (including certain exceptions and bonuses) that increase your score if you are part of a small practice, or meet certain other criteria. For those who seek to achieve a higher score, there are a number of other metrics to keep in mind to increase your score. Those "exceptional performers" who score more than 75 points will be eligible for an additional positive MIPS payment adjustment and may share in the pool of $500 million of funding available for the year.

Special Scoring Opportunities

CMS has developed special scoring that is available based on patient mix or practice composition. We summarize these opportunities below.

Complex Patient Bonus

CMS will add up to 5 points to your total MIPS score based on the clinical complexity of your patients. CMS determines complexity based on two factors: 1) the ratio of your Medicare patients who are "dual-eligible" and 2) the average Hierarchical Condition Category (HCC) risk score of your/your practice's patients. CMS calculates HCC risk scores as part of calculating the Cost category.

Small Practice Bonuses & Exceptions

CMS has changed the small practice bonus for the 2019 performance year. Previously, 5 bonus points were automatically added to a small practice's final MIPS score. Starting in 2019, CMS will add 6 measure points to the numerator of a small practice's Quality performance category score as long as the small practice submits data to MIPS

on at least 1 quality measure. The addition of 6 measure bonus points generally represents 10 percent of the quality performance category score for small practices. A small practice is either: 1) a practice with 15 or fewer MIPS-eligible clinicians; or 2) a solo practitioner.

Small practices receive double points for reporting IA measures. This means small practices can earn all the available points in the IA category by reporting two "medium-weighted" activities or one "high-weighted" activity.

If a small practice is not able to collect data for enough patients to meet the "data completeness" standard for a given Quality measure, it will still receive 3 points for that measure. Non-small practices earn one point under these circumstances.

For 2019, small practices can choose to apply for a "significant hardship exception" to have their PI category reweighted to 0%. More information about this application process is provided later in this document.

Non-Patient Facing Clinician Bonus & Exceptions

Non-patient facing clinicians and clinicians in non-patient facing groups will receive double points for Improvement Activities (i.e., they can receive full points in this category by reporting two "medium-weighted" activities or one "high-weighted" activity). A clinician is considered "non-patient facing" if they bill 100 or fewer patient-facing encounters during a 24-month non-patient facing determination period. For performance year 2019, the determination period will consist of two one-year periods running from September 1, 2017 to August 30, 2019.

"Patient-facing encounters" are comprised primarily of surgical and Evaluation and Management (E&M) services, and also include Medicare telehealth services. A group is considered "non-patient facing" if more than 75 percent of the NPIs billing under the group's Taxpayer Identification Number (TIN) or within a virtual group, as applicable, meet the definition of a non-patient facing individual MIPS clinician during that period.

Rural & Health Professional Shortage Areas Bonus

Clinicians located in a federally defined rural or Health Professional Shortage Area (HPSA) will receive double points for reporting IA measures. This means clinicians and groups located in these areas can receive all the available points in the IA category by reporting two "medium-weighted" activities or one "high-weighted" activity.

Quality Bonus Points

Bonus points can be earned by reporting more than one high priority or outcome measure. You need to report at least one outcome or high priority measure to meet the minimum Quality reporting requirements. Clinicians and groups can earn two bonus points in this category for every additional "patient experience and outcome measure," reported and one bonus point for every additional "high priority" measure reported by their practice. The number bonus points that may be earned is capped at six points. CMS has revised the definition of a high priority measure to include certain opioid-related measures. However, clinicians and groups that report quality measures through the CMS Web Interface are not eligible to receive high priority measure bonus points.

You can earn up to 10 additional percentage points on your Quality score if your 2019 performance has improved as compared to 2018. An improvement percent score is calculated by dividing the increase in the Quality category score from 2018 to the 2019 performance period by the 2018 quality category score multiplied by 10 percent. This potentially includes those who participated in 2018 under the "minimal" or "partial" track, and participate fully this year, if they reported Quality data.

You can earn one additional bonus point in the Quality category for every quality measure you report using "end-to-end" Certified Electronic Health Record Technology (CEHRT). To get this bonus, you must use CEHRT to collect, export, and transmit data to CMS (including through a third party vendor if it uses automated software to perform data aggregation, calculation, filtering, and data submission). In order to earn the end-to-end bonus in 2019, clinicians and groups need to use CEHRT that has been certified to the 2015 Edition.

Facility-Based Clinicians

A MIPS-eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by POS codes 21, 22, or 23 is eligible as an individual for facility-based measurement under MIPS. In order to be eligible for facility-based measurement under MIPS, a facility-based clinician must bill at least a single service with the POS codes for inpatient hospital (POS 21) or the emergency room (POS 23) and must be associated with a hospital with a Hospital Value-Based Purchasing (VBP) Program Total Performance Score. A facility-based group may also qualify for facility-based measurement and would be attributed to the hospital at which a plurality of its facility-based clinicians are attributed.

A clinician or group that qualifies for facility-based measurement under MIPS has no submission requirements for the Quality and Cost categories, but must submit data in the IA or PI performance categories to be measured under facility-based measurement. Where a clinician or group is measured under the facility-based measurement criteria, the Quality and Cost performance category scores for facility-based measurement are reached by determining the percentile performance of the facility in the Hospital VBP program for the 2019 performance year and awarding a score in MIPS associated with that same percentile performance in the MIPS Quality and Cost performance category scores for those clinicians who are not scored using facility-based measurement. CMS has stated that additional information on facility-based scoring will be available in 2019.

Special Status Exemptions

Certain "special status" clinicians are automatically exempted from the PI category, meaning their PI score will be reweighted to zero. These clinicians are as follows:

- "Hospital-based" clinicians who deliver 75% or more of their Medicare Part B services through a hospital
- Ambulatory Surgical Center (ASC)-based clinicians
- Health Professional Shortage Area (HPSA)-based clinicians
- Non-patient facing clinicians

If you are a clinician who is exempted from the PI category, the Quality category will reweighted to be worth 70% of your total MIPS score (an increase from 45% for other non-special status clinicians).

Significant Hardship Exemptions

Certain clinicians and groups may be exempted from the PI category, but they must apply to CMS to obtain an exemption for "significant hardship." If CMS grants an exemption, their PI score will be reweighted to zero. CMS will allow clinicians and groups to request this exemption online in the latter half of 2019, but you can begin to consider whether any of the below may apply to you:

- Insufficient internet connectivity: Clinicians who demonstrate that there were "insurmountable barriers" to obtaining internet infrastructure sufficient to submit data under the ACI category.
- Extreme and uncontrollable circumstances: This includes events such as natural disasters, closure of a practice or a hospital, severe financial distress (such as bankruptcy or debt restructuring).
- Lack of control over the availability of CEHRT: This includes situations where a practice is unable to access CEHRT for reasons beyond its control. This exception is granted if 50% or more of a clinician's outpatient encounters occur in a location where they have no control over the health IT decisions of the facility, such as clinicians who practice in multiple sites, or if they primarily practice through another entity (such as a SNF).
- Small practice: You must demonstrate that there are "overwhelming barriers" that prevent you from complying with the requirements of this category. CMS has said it will release more information about the application process for this exception later in the year.
- Decertification of CEHRT: Eligible if the CEHRT used by a practice was decertified during 2018 or 2019. Clinicians must demonstrate in their application and with supporting documentation that they made a good faith effort to adopt and implement another CEHRT.