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3 Things You Need to Know About MIPS in July 2019

#1: THE 2018 MIPS PERFORMANCE YEAR RESULTS ARE IN

CMS released the 2018 MIPS Feedback Reports earlier this month showing that participants who earned a perfect score of 100 points will receive a 1.68% payment adjustment that will be applied to their 2020 services. This is down from the 1.88% payment adjustment earned by the top performers in last year's MIPS program which, according to CMS, is due to a combination of high participation rates and high performance scores in 2018.

Remember, the MIPS program is required to be budget-neutral meaning that projected negative payment adjustments have to be balanced-out by the projected positive payment adjustments. With so many clinicians participating and achieving high performance scores, the positive adjustments have to be distributed to that many more participants.

Your 2018 MIPS final score will be between 0 and 100 points. For our clients and other practitioners who are classified by CMS as Non-Patient Facing and/or Hospital Based, the score is based on your performance in 3 MIPS categories, with each performance category carrying a different weight of the overall score:

- Quality 75%
- Improvement Activities 15%
- Cost 10% (If cost cannot be attributed to a participating clinician/group, it will be re-weighted to Quality, bringing that category to a weight of 85%)

Your MIPS final score is the sum of the above performance category scores plus any additional bonus points you may have been awarded such as those for small practice and/or complex patients. Some clinicians/groups additionally qualified for a Quality Improvement bonus. For the 2018 performance year, you had to earn 15 points to avoid a negative payment adjustment. Those earning scores of 70 points or higher were eligible for the exceptional performance bonus.

Based on your final score, your payment adjustment amount is calculated on a sliding scale (to maintain budget neutrality).

Final Score	MIPS Payment Adjustment
70.00 – 100.00 Points	Positive payment adjustment Eligible for exceptional performance bonus
15.01 – 69.99 Points	Positive payment adjustment Not eligible for the exceptional performance bonus
15.00 Points (2018 Performance Threshold)	Neutral payment adjustment (0)%
3.76 – 14.99 Points	Negative payment adjustment between 0% and -5%
0 – 3.75 Points	Negative payment adjustment of -5%

Information provided by APS Medical Billing, July 2019

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APS Practice Managers have begun notifying their clients of their 2018 scores and reviewing their reports with them. In the meantime, to learn more about the 2018 MIPS scoring and Feedback Reports visit:

https://qpp-cm-prod-content.s3.amazonaws.com/uploads/581/2018%20Performance%20Feedback%20FAQs.pdf

#2: CMS ANNOUNCES IT HAS BEGUN ITS DATA VALIDATION AND AUDIT (DVA) PROCESS ON MIPS DATA SUBMITTED FOR THE 2017 AND 2018 PERFORMANCE YEARS

As you know, CMS had previously declared its intent to perform audits of the data submitted to the MIPS program and, as such, has contracted with Guidehouse to begin with a select number of MIPS participants.

Approximately 40 Performance Measures/Activities will be selected for MIPS DVA, using a methodology created to select MIPS Measures/Activities with the highest identified risk that would prevent the MIPS program from achieving strategic goals. The number of Measures/Activities selected for DVA from each MIPS category will coincide with the category's weight for scoring purposes. This means there will be more auditing done in the Quality category than in the Improvement Activities category.

MIPS requires reporting on all-payer data, not just Medicare, when reporting to the program via data registry. Therefore, requests for records are not expected to be limited to services provided to Medicare beneficiaries but will encompass all applicable patients. According to CMS, the data from payers other than Medicare "will be used for informational purposes to improve future validation efforts and will not be the only source of data used to make final determinations on whether you pass or fail an audit…"

The Quality Payment Program requires CMS to cite the criteria used to audit and validate measures and activities for each performance year. For both the 2017 and 2018 performance years, the data validation process for the Quality category will include substantiating whether an individual/group submitted all applicable MIPS measures and encounters in any of these 3 circumstances:

- Fewer than the required 6 measures were submitted
- An Outcome or other High Priority measure wasn't reported
- Less than a full specialty measure set was submitted

Additionally, records may be requested to validate that all needed components for reporting a quality measure, such as services and diagnoses, timing or frequency parameters (if applicable) or patient age requirements (if applicable), are present in the clinician's documentation to support the CPT and ICD-10-CM code requirements that comprise the quality codes submitted to the program.

In the Improvement Activities category, the documentation that will be requested for review will need to confirm your/your group's "consistent and meaningful engagement" in each activity attested to. Here, we recommend you submit any and all documents tied to each of your reported Improvement Activities.

Those selected for data validation will receive a request for information directly from Guidehouse via email or certified mail. There is a 45 day deadline from the date of the notice to provide the requested information. If you receive such a notice and need assistance, please contact your APS Practice Manager.

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Select the below link for additional detail about the MIPS Data Validation and Audit process:

https://qpp-cm-prod-content.s3.amazonaws.com/uploads/0/MIPS%20Data%20Validation%20and%20Audit%20Fact%20Sheet.pdf

#3: CMS INTRODUCES FACILITY BASED MEASUREMENT FOR THE 2019 MIPS PERFORMANCE YEAR

Beginning this year, the MIPS program gives eligible physicians who are designated as facility-based and working primarily in hospitals, the option to have their Quality and Cost category scores based on their hospital's performance under the Hospital Value-based Purchasing (VBP) Program which is linked to the Inpatient Prospective Payment System.

The intent of this opportunity is to relieve clinicians participating in MIPS of the burden of reporting quality data to the program.

CMS offers a preview to eligible clinicians of what that mapping might look like but emphasizes that it is based on 2017 data. Given the continued evolution of CMS' quality initiatives, 2-year old data may not be optimal for making the decision to rely on a substitute source of data for the biggest part of your MIPS performance scores. Not to worry, here's how it's supposed to work:

- First, the eligible physician will be attributed by CMS to the facility where he/she services the most Medicare patients and that facility has to have a fiscal year 2020 Hospital Value-Based Purchasing score (VBP)
- Under the facility based measurement, the facility's performance score would replace the scores for the physician's/group's reported quality data and cost score (if that category is applicable to the group)
- Physicians do not have to declare their intent to use the facility's score for the quality and cost (if applicable) categories
- If physicians/groups submit their quality data as normal, CMS will bump that score against the facility's VBP score and apply the higher of the two to the provider/group's final MIPS score

As CMS will automatically compare the VBP score against the clinician's earned quality category score when performing final calculations for the 2019 performance year, we recommend that our clients continue reporting their quality data this year as normal and see how the results shake-out when the 2019 MIPS Feedback Reports are released next summer.

Click on these helpful documents that can also be found in the MIPS Resource Library:

https://qpp.cms.gov/about/resource-library
2019 Facility Based Measurement Fact Sheet
2019 Facility-based Preview FAQs