Nine-Step Guide to Reporting in the Merit-based Incentive Payment System (MIPS)

In 2018, you are required to participate in the MIPS track of the Quality Payment Program if you bill more than $90,000 to Medicare and provide care to more than 200 Medicare patients per year. However, if 2018 is your first year participating in Medicare or you are a Qualifying Participant (QP) in an Advanced Alternative Payment Model (APM), then you are not required to participate this year. The following is a nine-step guide to help prepare for the 2018 performance year.

1 **Do you have an Enterprise Identity Data Management (EIDM) account?**

Yes: Continue to step 2

No: Visit, **http://bit.ly/newEIDMacct**

2 **Access your 2016 Feedback Reports to gain an understanding of your quality and cost score** (2017 available Summer/Fall 2018)

Develop a quality improvement plan for measures below the national benchmark, high cost (spending) per beneficiary, hospital admissions for chronic conditions, and review attributed patients

http://bit.ly/QRURaccess

3 **Decide if clinicians in your practice will participate as a group or individually**

An individual is a single NPI tied to a single Tax ID Number. Payment adjustment is based on individual performance

A group is a set of clinicians sharing a common Tax ID Number whose Medicare payment is based on the group's performance

4 Determine if your EHR software is at least 2014 ONC Certified

https://chpl.healthit.gov/#/search

5 Consider your reporting period

- Submit minimum amount of data (15 points) to avoid a negative 5% payment adjustment
- Submit a full calendar year of 6 quality measures and any 90 days of Promoting Interoperability and Improvement Activities to avoid a negative payment adjustment and potentially earn a positive payment adjustment
- Submit no data and earn a negative 5% payment adjustment
- Data submission is not required for the cost category

Positive adjustments are based on the performance data submitted, not the amount of information or length of time submitted.

6 Select how your practice will report MIPS

For Individual Submission:

Quality: Qualified Registry, Qualified Clinical Data Registry (QCDR), EHR, and Administrative Claims (no submission required)

Promoting Interoperability: Qualified Registry, QCDR, EHR, and Attestation

Improvement Activities: Qualified Registry, QCDR, EHR, Attestation and Administrative Claims (if technically feasible; no submission required)

Cost: Administrative Claims (no submission required)

For Group Submission:

Quality: Qualified registry, QCDR, EHR, CMS Web Interface (groups of 25 or more), CAHPS for MIPS Survey (must be reported in conjunction with another data submission mechanism), and Administrative Claims (no submission required)

Promoting Interoperability: Qualified Registry, QCDR, EHR, CMS Web Interface (groups of 25 or more) and Attestation

Improvement Activities: Qualified registry, QCDR, EHR, Attestation, CMS Web Interface (groups of 25 or more)

Cost: Administrative Claims (no submission required)

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Choose which measures you will report on for each category:

Quality: Select 6 measures (one cross-cutting and one outcome measure) (50% of the final score)

https://qpp.cms.gov/mips/quality-measures

- Compare your measures to the current national benchmark data; **https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html**
- Select measures where the participant can exceed a benchmark that is not topped out
- Topped out measures receive 7 points

Promoting Interoperability: Identify your electronic health record edition (reporting varies based on edition). The more measures you select; the more credit you will receive. (25% of the score) **https://qpp.cms.gov/measures/aci**

- There are 5 base score objectives (required)
- Report 7–8 Performance Category objectives (depending on your CEHRT) — CEHRT can be found on **https://chpl.healthit.gov/#/search**
- Exclusions are available for e-prescribe and HIE

Consider bonus options (Ex. Reporting to a public health registry, using your EHR to report certain Improvement Activities, or using 2015 CEHRT for a full year.)

Improvement Activities: Determine how many points you need in this category and identify appropriate activities with documentation that supports those activities. **https://qpp.cms.gov/measures/ia** (15% of the final score)

Eligible Clinicians must achieve a total of 40 points from improvement activities during a 90-day reporting period. High weighted activities are credited 20 points, while medium weighted activities are 10 points. Thus, Eligible Clinicians are required to complete either four medium-weighted activities, or two high weighted activities, or any combination of high and medium-weighted activities for 2018

Exceptions:

- **Small practices, rural areas, practices located in geographic health professional shortage areas, and non-patient facing MIPS eligible clinicians** are only required to report one high-weighted or two medium-weighted activities.
- **Participants in Certified Patient Centered Medical Homes, comparable specialty practices, or an APM designated as a Medical Home Model** will earn full credit.
- Participants in other APMs will automatically earn half credit with the opportunity to select additional activities for full credit.
- **Consult the Final Rule for Improvement Activity credit given to APM participants**

Cost:

- 10% of the final score in 2018
- Based on 2018 administrative claims
- Compared to national benchmarks
  - Total Per Capita Cost
  - Medicare Spending per Beneficiary
- CMS calculates improvement from year to year and "awards" bonus points for improvement
- Review Feedback Reports (QRUR) from the previous year to fine tune workfllows and identify significant costs

8 **Prepare Audit Documentation & Retain for 10 years**

9 **Submit data through the previously selected reporting options beginning 1/1/2019 through 3/31/2019**

For more assistance in preparing for the Quality Payment Program, please consult HQI. Call our QPP Help Desk at **844.357.0589** or email **qpp@hqi.solutions**.

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