# MIPS in a Minute

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Healthcentric Advisors

The **Merit-based Incentive Payment System (MIPS)**, a payment model under the Quality Payment Program (QPP), requires eligible clinicians (EC) to report performance in the categories of: **Quality, Promoting Interoperability, Improvement Activities and Cost**. Overall performance in these categories will earn the EC a possible positive payment adjustment of **up to 7% on their Medicare Part B claims**. Failure to report will result in a negative 7% payment adjustment.

**How to Prepare for MIPS Participation in 2019:**

- Have your National Provider ID (NPI) and Tax ID (TIN) ready and check your participation status in the CMS lookup tool https://qpp.cms.gov/participation-lookup
- Determine whether to report as an individual or group
- Determine your data submission method: *Direct, Log in and upload, Medicare Part B claims (small practices only), Log in and attest, CMS web interface (groups of 25 or more)*
- Ensure you have 2015 certified Electronic Health Record (EHR) technology implemented by December 31st, 2019
- Obtain a valid HARP (HCQIS Access Roles and Profile) account
- Determine the quality measures and Improvement Activities to report on and plan to submit all required measures for the Promoting Interoperability category or take applicable exclusions
- Run performance reports to evaluate your performance in your selected measures and activities on at least a quarterly basis

## MIPS Program Requirements

### Determine Eligibility

Eligible clinicians and groups who meet the following low-volume threshold criteria are expected to report under MIPS:

- Have $90,000 or more in Part B allowed charges for covered professional services from the Physician Fee Schedule;
- Provide care to 200 or more unique Medicare beneficiaries;
- Provide 200 or more covered professional services under the Physician Fee Schedule

Clinicians or groups have the ability to opt-in to participate in MIPS if they meet or exceed one or two, but not all three, of the low-volume threshold criteria.

### Participating in MIPS

**Avoid a Payment Penalty**: submit data to achieve at least 30 MIPS performance points

**Earn a Positive Payment Adjustment**:

- ❑ **Small positive payment adjustment** – submit data to earn between 30.01 -74.99 MIPS performance points
- ❑ **Modest positive payment adjustment** – participate fully by submitting data to earn 75+ MIPS performance points and be eligible for an exceptional performer bonus

# Merit-based Incentive Payment System – Performance Year 3

## Eligible Clinician Types

Eligible clinician (EC) types for the 2019 MIPS performance year are defined as:

- Doctors - Medical Doctor, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Dentistry, Doctor of Chiropractic, Doctor of Ophthalmology and Doctor of Surgery
- Physician Assistants (PA)
- Nurse Practitioners (NP)
- Clinical Nurse Specialists (CNS)
- Certified Registered Nurse Anesthetists (CRNA)

**In 2019, the definition of MIPS eligible clinicians has been expanded to include:**

- Physical Therapists
- Occupational Therapists
- Audiologists
- Speech-Language Pathologists
- Clinical Psychologists
- Registered Dietitians/Nutrition Professionals

## Report as an Individual or Group

- If you report as an **individual**, you'll report measures and activities for the practice(s)/ TIN(s) under which you are MIPS-eligible and be assessed across all four performance categories at the individual level.
- If you report as a **group**, the group's performance data is aggregated across the four MIPS performance categories for the TIN. Each MIPS-eligible clinician in the group will receive the same payment adjustment based on the group's MIPS performance score.

## Special Status Considerations

When reviewing the QPP participation lookup tool, there are several special status designations that may be present:

- **Hospital-based:** The clinician furnishes 75% or more of his or her covered professional services identified by the Place of Service (POS) codes 19, 21 22, or 23
- **Non-patient facing:** The clinician has 100 or fewer Medicare Part B patient-facing encounters annually
- **Ambulatory Surgery Center-based:** The clinician furnishes 75% or more of his or her covered professional services in sites of service identified by Place of Service (POS) code 24
- **Small practice:** A clinician's practice size is 15 or under
- **Rural:** The clinician practices in a zip code designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data.
- **Health Professional Shortage Area (HPSA):** The clinician is associated with a practice that is in an area designated under section 332(a)(1)(A) of the Public Health Service Act.

*This material was prepared by the New England QIN-QIO, the Medicare Quality Innovation Network-Quality Improvement Organization for New England, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. CMSQIND12019031719*

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