How to **NAVIGATE** the Land of MIPS

For the majority of clinicians, the Merit-based Incentive Payment System (MIPS) is their first experience in a CMS pay-for-performance program. Participation in this highly complex program can be difficult to navigate. Clinicians must stay current on evolving program requirements each year. **Use this map to understand the program's participation requirements, performance measurement, and financial impact.**

Rules of the road

To pursue success under MIPS, follow these four steps:

Step 1
Determine program eligibility and select participation option(s)

Step 2
Achieve points in each of the four performance categories (the "lands" described below)

Step 3
Report program performance to and receive score from CMS

Step 4
Anticipate the impact of future MIPS payment adjustments

Participation requirements

Who are the 798,000+ eligible clinicians setting out on the MIPS journey?

The following provider types are eligible for MIPS if they bill Medicare Part B:

- Physicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Physical therapists
- Occupational therapists
- Clinical psychologists
- Registered dietitians
- Nutrition professionals

What are the participation options?

Clinicians can report individually or as part of a group

Individual
Unique NPI/TIN

Group
Single TIN

Virtual group
Multiple groups (each TIN ≤10 clinicians) can band together

Alternative payment model (APM) entity
Clinicians who participate in a MIPS APM are assessed collectively

Who stays home?

To be excluded from MIPS, clinicians or groups need to meet one or more of the following four criteria:

- Enrolled in Medicare for the first time during the program year
- Participate in an advanced APM and are determined to be a qualifying APM participant (QP)
- Participate in an advanced APM, are determined to be a partial QP, and do not elect to participate in MIPS
- Falls below the low-volume threshold

Performance measurement

Land of **quality**

PERFORMANCE PERIOD
12 months

CMS DATA SUBMISSION REQUIRED?
Yes

Path to points:

Select and report clinical quality measures (CQMs)

- Electronic CQMs from an electronic health record (EHR)
- MIPS CQMs through a registry
- Qualified clinical data registry (QCDR) measures
- CMS Web Interface (groups of 25 or more clinicians)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey
- Claims-based measures (groups of ≤15 clinicians)

Land of **cost**

PERFORMANCE PERIOD
12 months

CMS DATA SUBMISSION REQUIRED?
No

Path to points:

Receive points for applicable cost measures

- Medicare spending per beneficiary
- Total per capita cost
- Eight episode-based cost measures
  - Five procedural episode-based measures
  - Three acute inpatient medical condition episode-based measures

Land of **improvement activities**

MINIMUM REPORTING PERIOD
90 days

CMS DATA SUBMISSION REQUIRED?
Yes

Path to points:

Report any combination of medium- and/or high-weighted activities to earn all available points

- High-weighted activity example
  - Engage patients and families to guide improvement in the system of care
- Medium-weighted activity example
  - Participation in quality improvement initiatives

Land of **promoting interoperability**

MINIMUM REPORTING PERIOD
90 days

CMS DATA SUBMISSION REQUIRED?
Yes

2015 edition certified EHR technology (CEHRT) required in 2019 and beyond

Path to points:

Conduct a security risk analysis and report performance-based measures from four objectives

1. Electronic prescribing

- Electronic prescribing

Bonus:

- Query of Prescription Drug Monitoring Program
- Verify opioid treatment agreement

2. Health information exchange

- Support electronic referral loops by sending health information
- Support electronic referral loops by receiving and incorporating health information

3. Provider to patient exchange

- Provide patients electronic access to their health information

4. Public health and clinical data exchange

Choose 2 of the following:

- Syndromic surveillance
- Immunization registry
- Electronic case reporting
- Public health registry
- Clinical data registry

Financial impact

Final score

Clinicians gather points across MIPS categories (the "lands" detailed above) to receive a final MIPS score that ranges from 0 to 100. More points are available in some categories than others (e.g., Quality is 50% of the total MIPS score in 2019). The final cumulative MIPS score determines the future negative, neutral, or positive payment adjustment.

Payment adjustment

MIPS payment adjustments are applied to Medicare Part B professional services in the payment year that is two years after the program year (e.g., the 2019 MIPS score determines the 2021 MIPS payment adjustment).

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