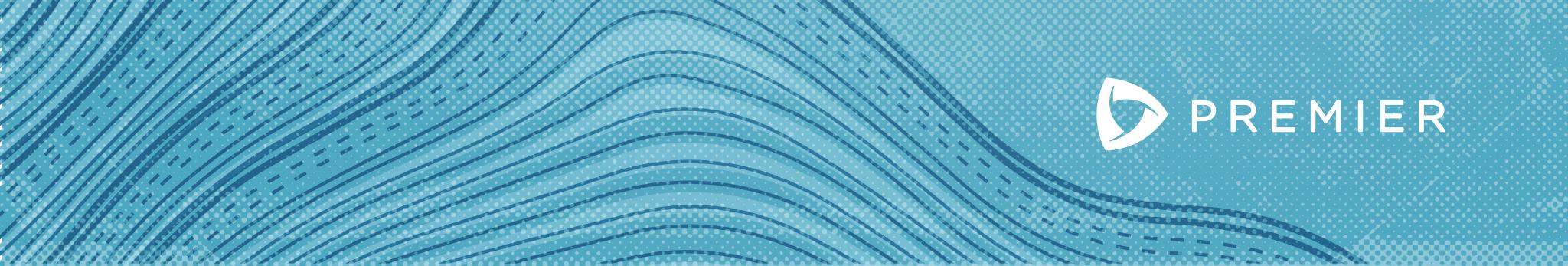


A Clear Path to Quality Improvement: **MIPS 2018** AND BEYOND

Strategies to simplify data reporting so you can focus your energy on where it belongs: optimal patient care.



Contents

01

See the Forest for the Trees

Get Your Bearings



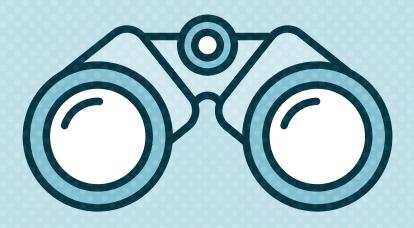
Survey the Changing Terrain

Consult Your Atlas



Refocus Your Energies





See the Forest for the Trees

 Busy healthcare clinicians have spent many caffeinated mornings and lamp-lit evenings exploring the myriad details of the MIPS program.
 If you're feeling overwhelmed by deadlines and changing requirements,

you are far from alone.

This guide will help you get up to speed on the latest changes in the MIPS program as you work to educate your team and streamline reporting practices for 2018 and beyond. A clear path to MIPS performance success will help reduce the distractions that interfere with your most essential goal as a medical provider – providing excellent patient care.

MLER SI





Get Your Bearings

0

A Brief History of MIPS

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA). The bill was designed to create a more predictable and sustainable model for the Medicare Part B reimbursement system. From MACRA was born the Quality Payment Program (QPP), which was designed to lower healthcare costs and improve patient care by rewarding clinicians for achieving value-based care milestones. The QPP consists of two major tracks:

MIPSo

Merit-based Incentive Payment System

> APMS • Advanced Alternative Payments Models

MIPS is the default track for over 80 percent of clinicians. The Advanced APM route is a bonus track for providers willing to assume a larger financial risk under value-based payment contracts for a large portion of their patient population.

Although the majority of providers will fall into the MIPS track, many physician groups and hospitals will work towards optimizing their performance under MIPS to prepare for future participation in the Advanced APM model.





Check Your Compass: What's New for 2018?

Below are some of the more significant changes for MIPS Year 2 :

• Virtual Groups have been added as a reporting option.

 The weight of the Cost category has increased from 0 percent to 10 percent. The weight of the Quality category has decreased to 50 percent. Starting with the 2019 performance period, Cost will increase to 15 percent and Quality will be weighted at 45 percent.

• Practices of 15 or fewer clinicians will receive an automatic

- five-point bonus to their MIPS final score.
- Addition of a complex patient bonus: eligible clinicians may receive up to five bonus points for complex patients.
- Performance period extended for the Quality and Cost categories to 365 days, from Jan. 1, to Dec. 31, 2018. The performance period for the Promoting Interoperability (PI) and Improvement Activities (IA) categories is any consecutive 90 days. The window to begin tracking the data for the PI and IA categories is Jan. 1, to Oct. 2, 2018.
- The low-volume threshold has increased. Clinicians who provide care to fewer than 200 Medicare Part B beneficiaries and bill less than \$90,000 in Medicare Part B payments are exempt from MIPS.
- Hardship exemptions are available to practitioners affected by natural disasters and other uncontrollable circumstances. In addition to the previous exemption in the Promoting Interoperability category, QPP has extended this policy to the other categories for 2018. The deadline to apply for the hardship exemption in these categories is Dec. 31, 2018.





Who Qualifies for MIPS?

You are eligible for the MIPS track if:

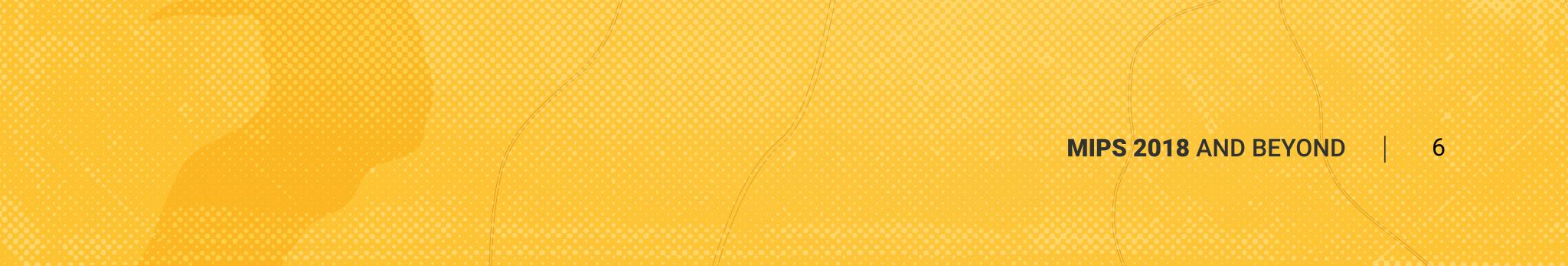
Olo You bill more than \$90,000 per year in Medicare Part B allowed charges; **AND**



Provide care to more than 200 Part B enrolled Medicare patients per year; **AND**

°03

You are a physician, physician assistant, nurse practitioner, clinical nurse specialist or certified registered nurse anesthetist.





How Does MIPS Work?

Providers participating in MIPS will earn a performance-based adjustment by reporting patient care data, as well as reporting how their practice used technology during the year. The MIPS scoring method is called the MIPS final score. This score determines the amount providers earn using four weighted performance categories. **The categories are:**

Quality

Previously: The PQRS Program Category weight: 50% of total MIPS score Maximum points: 60 Performance period: 365 days Requirements:

- Submit six Quality measures.
- Submit one Outcome measure, unless one is not available in your specialty. In that case, submit a high priority measure in its place.
- If you report via the Center for Medicare and Medicaid Services (CMS) Web Interface, report 15 Quality measures.

Getting into the weeds

 Submitting the Consumer Assessment of Healthcare Providers and Suppliers (CAHPS) Survey counts as reporting one high priority measure. Select five other Quality measures to report, including an Outcome measure, if available.

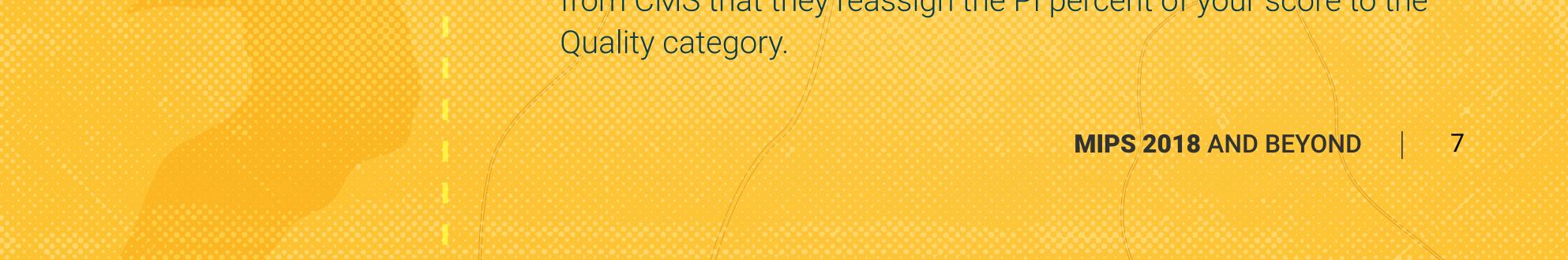
O Promoting Interoperability

Previously: Meaningful Use for Eligible Professionals,
Advancing Care Information
Category weight: 25% of total MIPS score
Maximum points: 155 possible, capped at 100
Performance period: 90 days
Requirements:

- Report required base measures.
- Choose from Performance measures to reach the 100-point threshold.

Getting into the weeds

- You must report all four base measures.
- If the PI measures aren't relevant to your practice, you can request from CMS that they reassign the PI percent of your score to the





How Does MIPS Work?

Improvement Activities

Previously: New Category Category weight: 15% of total MIPS score Maximum points: 40 Performance period: 90 days Requirements:

- Submit up to four Improvement Activity measures to reach a maximum of 40 points. This could be four medium-weighted activities, two high-weighted activities or a combination.
- Practices with fewer than 15 clinicians; practices in rural areas, health professional shortage areas; and non-patient-facing MIPS eligible clinicians need only two Improvement Activities or one high-weighted activity for a total of 20 points.
- Patient Centered Medical Home (PCMH) models automatically receive full credit.

O Cost

Previously: Value-Based Modifier Category weight: 10% of total MIPS score Performance period: 365 days Requirements:

• This category is claims-based and will be automatically calculated by CMS. No data submission is required.





A New Reporting Option for Groups

The Quality Payment Program (QPP) announced a new group reporting option at the end of 2017 called **Virtual Groups**. Although the deadline has passed for 2018 virtual group election, some small group practitioners may want to consider this option for 2019 and beyond. More information about virtual groups can be found in the <u>CMS Virtual Groups Toolkit</u>. Options for reporting include:

Individual •

An individual reporter is a single clinician identified by a single National Provider Identifier (NPI) number tied to a single Tax Identification Number (TIN).



A group is defined as two or more eligible clinicians (including at least one MIPS eligible clinician) who share a TIN. Group members are identified by individual NPIs.

Large Practice

Groups of 25 or more providers may submit data using the CMS Web Interface. If this option is chosen, 365 days' worth of data must be reported, including 30+ measures.

Virtual Group •

A Virtual Group allows combinations of solo providers or groups of 10 or fewer providers to combine under the umbrella of two or more "virtual" TINs for one performance year. The specialty or location of the practitioners is not important. One caveat is that the low-volume threshold for MIPS participation must still be met. The election deadline for 2019 participation is Dec. 31, 2018.



Survey the Changing Terrain

• What happens once my practice's MIPS final score is determined?

Your MIPS final score has a significant impact on both the reputation and the finances of your practice.

Reputation \mathbf{O}

- CMS publishes the Physician Compare Initiative webpage to help
- consumers evaluate and compare clinicians and clinical quality statistics.
- Monitoring this page will allow you keep track of how your MIPS data is
- contributing to your efforts.



• Financial

- The MIPS final score results determine a negative, neutral or positive
- financial adjustment for clinicians on each Medicare Part B claim.
- How you choose to participate each year determines your success.
- The score is based on what you choose to report from the four
- performance categories and is calculated on a scale from zero
- to 100 points.

This year, QPP added some exemptions for smaller practices and those hit hardest by extreme circumstances, such as natural disasters, to help reduce some of the burden of the ongoing process. However, if your practice does not fall into these categories, be aware that the cost for not participating in MIPS is steep. You stand to lose five percent of each 2020 Medicare fee reimbursement and the penalty

increases yearly.

On the other hand, successful MIPS data reporting means you'll avoid the 5% penalty and potentially earn a small incentive. These positive payments are also set to increase yearly. Top performers will find themselves eligible for additional bonus money. The number of points earned will determine your opportunities for positive payment adjustments and bonus money.



0



Up to 5% penalty

No

adjustment

Some incentive

• •		
	• • • •	

Higher incentive + bonuses



A Guide to Bonus Points

5 points

Small Practice Bonus: Automatically added for qualifying providers.

5 points

Public Health Registry Measure Bonus: Earn 5 points for submitting an additional PHR measure not reported under the performance score.

Up to **5 points**

Complex Case Bonus: Automatically added for qualifying providers.

Up to 10 points

Improvement Bonus: Demonstrated improvement on 2018 Quality or Cost score.

Up to 6 points	Additional Measure Submission: Submit an additional Outcome, High Priority or Patient Experience measure.
Up to 10 points	Promoting Interoperability Bonus: Submit select Improvement Activities within the PI category.
Up to 6 points	Certified Electronic Health Record Technology (CEHRT) Submission: Submit Quality measures via CEHRT.
Up to 10% Bonus on PI score	2015 Edition CEHRT Bonus Points: Use only the 2015 edition of CEHRT to submit 90 days of PI measures.





• Ready to Explore a Bit More?

A few deadlines:

The last day to submit performance data for 2018 is March 31, 2019. For
the Quality and Cost categories, this would mean data that was tracked
from Jan. 1, 2018 through Dec. 31, 2018. For the Promoting Interoperability
and Improvement Activities, this would mean data tracked any consecutive
90 days during the year. As mentioned above, the deadline to form a Virtual
Group for 2019 is Dec. 31, 2018.

How should I report my data?

1--t

You may use different methods to report different categories, but only one method can be used within each category.

PREMIER MIPS 2018 AND BEYOND

• **Reporting Options:**

- Qualified Clinical Data Registry (QCDR)
- Certified Electronic Health Record Technology (CEHRT)
- Qualified Registry (QR)
- Medicare Part B claims-based reporting
- CMS Web Interface (for groups of 25 or more eligible clinicians)
- Consumer Assessment of Healthcare Providers and Suppliers (CAHPS) for MIPS (counts as one Quality measure; remaining measures must be reported using one other reporting method)

Some medical specialties have already made the shift away from the claims-based reporting system. Others, for now, continue to use this familiar payment mechanism. However, according to CMS, "claims reporting captures only about 40% of eligible reporting opportunities."

Moving to a registry may appear to be somewhat of a challenge at first, but taking this step can offer significant opportunities to improve performance, not just with MIPS compliance, but also in the realm of patient care and communication.





A Navigating Partner: How a Registry Can Help

 A registry partner can help you analyze your current performance on data submission and quality measures. This information can then be used to determine the way forward by helping you select which reporting strategy is most appropriate for your practice or network. The result should be one integrated system that provides a view of all involved clinicians' performance across all four MIPS categories.

The registry then takes on the job of MIPS reporting: aggregating,

analyzing, calculating and submitting the data on your behalf. These types of solutions can be tailored to fit any size organization, from large multidisciplinary networks to small group or solo clinicians.

With the data reporting taken care of, you can focus on improving patient care and MIPS reimbursement by viewing and sharing the collected information all in one place. Aligning clinician measures in this way allows you to create and optimize shared goals between clinicians in various care settings.



-• Refocus Your Energies

Patient care improvements by individual clinicians will advance

- some of the larger shared goals of the healthcare community. Switching from a volume-based to a value-based payment program moves us closer to achieving the aims of better care, healthier communities and lower costs.
- More importantly, spending time on planning, outreach and care coordination should allow for increased ability to offer cost-effective and patient-centered care.

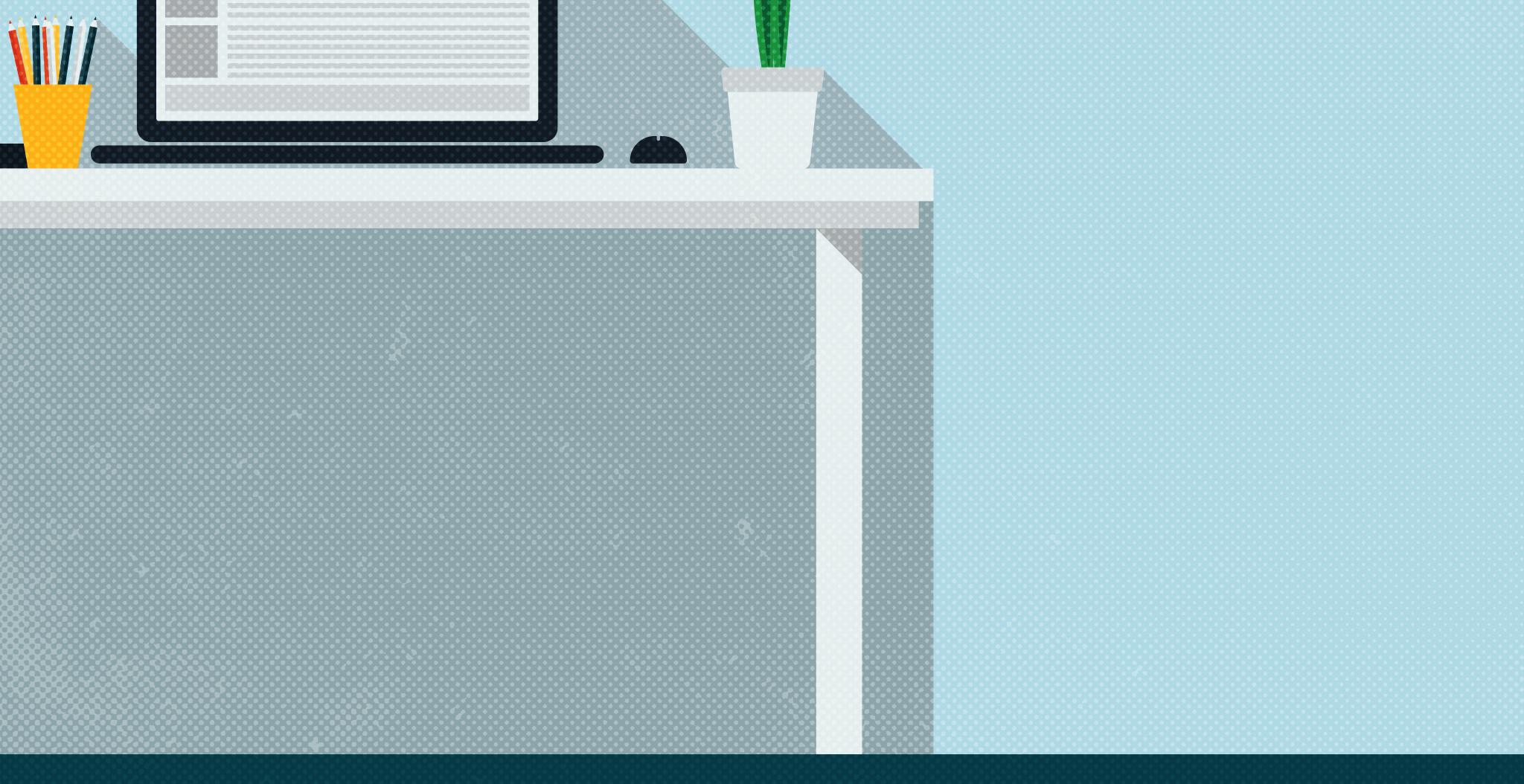
The frequent changes in today's healthcare environment can be dizzying and distracting. Despite the increasing complexities, the ever-present need for compassionate medicine remains the same. A guiding partner can help you take on the challenges related to MIPS reporting so you can concentrate on what matters most: caring for your patients.



Ready to Get Started?

Contact Premier today to assess the impact of MIPS on your practice, determine your best reporting method and optimize your strategy.

Learn More at solutions.premierinc.com.



* "Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models," Department of Health and Human Services. Page 1137.

Premier[®] (NASDAQ: PINC) is a leading healthcare improvement company, uniting an alliance of approximately 3,900 U.S. hospitals and more than 150,000 other provider organizations. With integrated data and analytics, collaboratives, supply chain solutions, and advisory and other services, Premier enables better care and outcomes at a lower cost. Premier, a Malcolm Baldrige National Quality Award recipient, plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, NC, Premier is passionate about transforming American healthcare. Please visit Premier's news and investor sites on www.premierinc.com for more information about the company.



51:E

13034 Ballantyne Corporate Place, Charlotte, NC 28277 | 877.777.1552 © 2018 Premier Inc. All Rights Reserved.

