MIPS Frequently Asked Questions

Q: Which reporting mechanism should I choose?

A: Six core options are available: Qualified Registries, Qualified Clinical Data Registries (QCDR), EHRs, CMS Web Interface, Attestation or Claims, and CMS-certified vendors for CAHPS. Reporting mechanisms differ widely in regards to available measure selection, potential for bonus points, and data tracking capabilities. You can filter measure options on qpp.cms.gov. Ideally, you should choose a reporting mechanism that will allow you to report across all categories in order to reduce reporting burden. Finally, financial and labor costs can vary across mechanisms and need to be weighed.

Q: What happens if a provider joins a qualified AAPM after the roster submission date. I.E. NextGen ACO rosters are due to CMS in summer. What happens to the clinicians who join a practice that is part of the ACO, but after the roster is submitted in June?

A: These providers would be MIPS eligible. CMS will make QP determinations three times during the performance period (March 31, June 30, and August 31). To be included in QP calculations, a clinician must be on the AAPM's participation list during at least one of these snapshots. If they are not on the participant list during the determination period, they fall into the MIPS track. Some physicians under a TIN may participate in the ACO, while others in the TIN are part of the practice, but not part of the ACO. In this situation, the ACO participants receive the score of participating in an AAPM, while the other physicians receive the MIPS group score.

Q: How will CMS derive the low-volume threshold (>100 Medicare patients / <30,000 charges)?

A: CMS will a review your claims during two determination periods. September, 2015 – August, 2016 and September, 2016 – August, 2017. If you meet the low volume threshold during either period, you will be exempt. CMS will send a letter to notify clinicians.

Q: Is the low-volume threshold determined at the group or individual level?

A: Low-volume threshold will be applied at the individual level for those reporting individually and at the group level for those reporting as a group. Note that a clinician may be excluded at the individual level, but unless every clinician in their TIN meets the low volume threshold, he/she will be required to participate as part of the group.

Q: What if a clinician (NPI) bills under multiple TINs?

A: If a clinician bills under multiple TINs, CMS will apply the highest final score associated with that NPI in the performance period.

Q: How will CMS notify clinicians if they are exempt from MIPS reporting?

A: CMS has stated that they will send out letters at the end of March. A portal where you can check your status is also supposed to be created, but as of March 20th, has not been finalized.

Q: How should I decide which quality metrics to report on?

A: Scoring well in the quality category is crucial to success in 2017 as it accounts for the majority of one's composite score. Groups should strategically chose measures that they will score well on. Six measures must be reported, one of which must be an outcome measure. If an outcome measure is not available that is applicable to your specialty or practice, chose another high priority measure. Bonus points will be available for groups that choose to report on additional

outcome measures. For primary care, our list of recommended measures was derived from cross referencing the Affinia Quality Handbook, ACO measures, and QPP measures. For specialists, you can filter options on qpp.cms.gov which may include fewer than six measures. If the specialty measure set includes more than six measures, clinicians can choose six from the set. According to CMS, MIPS eligible clinicians or groups are expected to report on applicable measures. "Applicable" is defined as measures relevant to a particular MIPS eligible clinician's services or care rendered. MIPS eligible clinicians can refer to the measures specifications to verify which measures are applicable. Not all measures in each specialty measure set will be applicable to all clinicians in a given specialty. If the set includes less than six applicable measures, the eligible clinician should only report the measures that are applicable. Finally, you should evaluate your QRUR in order to determine which measures you successfully reported in PQRS.

Q: How should I decide which improvement activity metrics to report on?

A: This category is based on attestation (only requires a Yes / No response for all activities). We predict that most groups across the country will earn full credit in this category as it's inclusive of many options and is noncompetitive. There are two types of measures; high (20 points) and medium (10 points) weighted activities. In order to earn full credit, groups must earn 40 points, by reporting any combination of high and medium weighted measures. PCMH practices will automatically get full credit and small / rural practices only need to report 20 points of activities to receive full credit (one high weighted or two medium weighted). A small practice is defined by CMS as a practice with 15 or fewer clinicians. Groups also need to be cognizant about documentation. CMS has not yet released guidelines regarding documentation, but they have stated that random audits are likely to occur. Groups should save documents, dates, presentations, minutes, and other meeting materials that support any improvement activities. *When reporting as a group, all clinicians will receive the same score. If at least one clinician within the group completes the activity, the whole group will receive credit.

Q: How should I decide which advancing care information measures to report on?

A: This category does not allow for much choice. It necessitates the use of certified EHR to report. In 2017, you may use 2014 or 2015 CEHRT, but in 2018, you have to use 2015 CEHRT. Scoring for this category is relatively complex. The ACI category requires minimum "base" measures which are worth 50 points. If you do not report on all required measures of the base score, you will not earn any credit in the ACI category (must report a numerator of at least one or attest, "Yes" for every base measure). Together the base measures account for 50% of the category score, and reporting data for additional performance and bonus measures will account for the other 50% (the maximum score is 100%). For the base measures, the group only needs one clinician to report successfully to achieve a "yes" or a numerator of 1 for each measure to get credit. This means that as long as one clinician completes all base measures, then the whole group will get credit for the base measures (50% of the score). For performance measures, groups need to report the sum numerator and denominator across all providers using a CEHRT and those totals will be used as the numerator and denominator for the group. So for the performance category, one clinician attesting will not earn full credit. Finally, bonus points are available for clinicians who report certain clinical improvement activities using CEHRT and for reporting to one or more additional public health and clinical data registries (beyond the Immunization Registry Reporting).