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10 KEY MIPS UPDATES FOR 2019

What has changed in Year 3

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10 Key MIPS Updates for 2019

Introduction

On November 1, 2018, the Centers for Medicare & Medicaid Services CMS) released the 2019 Quality Payment Program (QPP) Final Rule. The performance year is 2019, and payment adjustment year is 2021.

These changes are effective January 1, 2019. They are reflective of stakeholder feedback according to CMS.

In this e-book we will present what you need to know for MIPS year 3.

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Eligible Providers

Eligible Providers have been updated to include:

- Physical Therapists
- Occupational Therapists
- Clinical Psychologists
- Qualified Speech-Language Pathologists
- Qualified Audiologists
- Registered Dieticians or Nutrition Professionals

To see the participation status of a provider, go to the QPP website and search using the provider's NPI.

QPP look-up

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Participation

Providers who meet all three of the criteria below within the specified determination periods are eligible & must report unless they are part of an advanced payment model. If they do not meet all three, the provider is qualified for *low volume exemption.*

- Determination Period:
    - 10/01/2017-09/30/2018
    - 10/01/2018-10/09/30/2019
- Criteria:
    - Billed $90,000 or more in allowed charges for Part B services
    - Saw 200 or more Part B beneficiaries
    - Provided 200 or more covered services to part B patients (new in 2019)

Opt-In- A provider may elect to Opt-in if they exceed one or two of the criteria noted above. Doing so will cause the provider to receive a payment adjustment either positive or negative, or neutral in 2021.

NOTE- Once the provider chooses to opt-in they must participate for the applicable reporting period.

Voluntarily Report- A provider may elect to voluntarily report if they exceed one of the threshold criteria above. This will result in no payment adjustment in 2021.

Category Weighting

- **Quality** – 45% (v. 50% in 2018)

- **Promoting Interoperability** – 25% (previously called Advancing Care)

  The EHR must be a 2015 certified edition to report in this category, and the scores are based on 4 required objectives:

  - E-prescribing
  - Health Information Exchange
  - Provider to Patient exchange
  - Public health and Clinical Data exchange
  - Note: The Security Risk Analysis is still required in 2019, however it will no longer have any points assigned to it.

- **Improvement Activities** – 15%

  A key update for 2019 are the new improvement activities which have been added, including:

  - Comprehensive Eye Exams
  - Financial Navigation Program
  - Completion of Collaborative Care
  - Management Training Program
  - Relationship Centered Communication
  - Patient Medication Risk Education
  - Use of CDC Guidelines for Clinical Decision Support to Prescribe Opioids for Chronic Pain

- **Cost/Resource Use**- 15% (v. 10% in 2018)

  This category is not "reported" by the provider, but calculated by CMS based on Medicare spending per beneficiary (MSPP), & total per capita cost measures. This is based on:

  - A case minimum of 35 for MSPP
  - A case minimum of 20 for the total per capita cost measure

Category Performance periods for 2019

- Quality – 12-month calendar year
- Cost- 12-month calendar year
- Promoting Interoperability – 90 Day minimum within the calendar year
- Improvement Activities- 90 day minimum within the calendar year

CMS estimates that just over 91% of eligible clinicians who participate in MIPS will either receive a positive or neutral adjustment.

To learn more, visit the CMS QPP website here CMS QPP

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