MIPS 2020

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UPDATED MIPS INFORMATION INCUDING NEW COVID-19 ADDITIONS

Lois Stewart-Wiebe 7/29/20

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MIPS OVERVIEW

QPP is a CMS program which requires all eligible providers to report on a variety of quality measures either by MIPS or through the Advanced Payment Model(APM). This e-book is a review of what has changed, eligbility requirements, including exemptions available, and resources for the MIPS program. See the Resource page for weblinks with more information.

While it is required, there is an opportunity for a bonus if the provider's scores 45 points or higher applied as well as for additional payment as a bonus from CMS is based on the completeness of the data received. However, if the reporting falls short of their requirement, there is a negative payment adjustment applied to any payments in 2022. In 2020 the negative payment adjustment/bonus is 9% of the payments in the 2022 payment year.

- Payment adjustment/bonus will be applied as follows:
  - 9% for thos providers who score less than 11.25 pts.
  - A scalling factor will be applied based on the score for those providers who score between 11.26 – 44.99 points
  - A neutral adjustment is applied for providers scoring 45 points
  - A scalling factor positive bonus is applied to providers scoring 45- 84.99 points
  - Additional scaling factor applied to providers who score 85 points or higher

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ELIGIBILITY:

Determination Periods.

A provider must exceed the low volume threshold in *both* periods in order to be required to report.

- 10/01/2018-09/30/2019
- 10/01/2019-09/30/2020

Low Volume Threshold

A provider must exceed all 3 in order to be required to report.

- Bill more than $90,000 for Part B covered professional services, *and*
- See more than 200 Part B patients, *and*
- Provide more than 200 covered professional services to Part B patients.
- *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.

Eligible Providers types

There was no change in 2020. See the list below. Final determination of eligibility status from CMS of the providers QP will be released on the QPP site in November 2020. See link in Resources.

- Physicians (MDs., DOs, Dental medicine/surgeons, podiatric medicine and optometry)
- Osteopathic practitioners
- Chiropractors
- Physician Assistants
- Nurse Practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Physical Therapists
- Occupational Therapists
- Clinical Psychologists
- Qualified Speech-Language Pathologists
- Qualified Audiologists
- Registered Dieticians or Nutrition Professionals

REPORTING:

Providers may report as:

- **An Individual-** Payment is tied to the individual provider NPI
- **Part of a group-** Payment is based on the group's combined performance under a single NPI/TIN
- **Part of a virtual group –** A combination of 2 or more TINs made up of solo practitioners and groups of 10 or fewer clinicians who come together "virtually." Specialty and location are not applicable to virtual groups.

Reporting Submission Methods:

- Qualified Clinical Data Registry
- EHR Registry
- CMS Web-interface for groups of 25 or more providers
- Claims- this is for small practices only

CATEGORIES & WEIGHTING:

Quality (45%)

The provider must report on 6 quality measures found on the QPP site**. (**Link in Resources)

NOTE: CMS has added a quality measure for COVID-19. To receive credit providers must attest that they have:

- ❖ Participated in a COVID-19 clinical trial & the data must be entered into a data platform for that study **OR**
- ❖ Participated in the care of COVID-19 patients and submitted clinical COVID patient data to a clinical data registry for the purposes of future study**.**

Promoting Interoperability (25%)

This category relates to data pulled from your EHR. 2015 CEHRT is required. Scores are based on 4 required objectives:

- E-prescribing
- Health Information Exchange
- Provider to Patient exchange
- Public health and Clinical Data exchange
- ❖ Special Status: Providers with these statuses are not required to report in this category. The 25% weighting will be redistributed to another performance category (or categories).

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- Ambulatory Surgical Center (ASC)
- Hospital Based
- Non-patient facing

NOTE: Exceptions to reporting this category may be applied for one of the following reasons:

- MIPS eligible clinician in a small practice
- MIPS eligible clinician using decertified EHR technology
- Insufficient Internet connectivity
- Extreme and uncontrollable circumstances
  - **CMS has added the COVID-19 pandemic as an extreme and uncontrollable circumstance**. Providers will need to document in their application how COVID-19 impacted your ability to collect data for an extended period of time, or could impact their performance on cost measures.
- Lack of control over the availability of CEHRT

Improvement Activities (15%)

These activities have a minimum 90-day continuous period unless otherwise stated in the activity description. Note: If reporting as a group or virtual group at least 50% of the clinicians in the group must perform th**e** same activity. More information and a list of activities may be found here.

- 2 High-weighted activities
- 1 High-weighted activity and 2 medium weighted activities
- 4 medium weighted activities

Cost (15%):

This is calculated by CMS based on data collected by CMS and is not separately reported by the provider. It has been revised as follows:

- Medicare Spending per Beneficiary
  - The name has been changed to Medicare Spending Per Beneficiary Clinician (MSPB) .
  - Methodology has been refined for medical and surgical episodes
  - Service exclusions for cost that are unlikely to be influences by clinicians
- Total Per Capita Cost (TPCC)
  - Refined attribution methodology for identifying primary care relationships
  - Specialty exclusions for clinicians who do not provide primary care services
  - Refined risk adjustment to account for changes in patient health status during the year
- Added 10 new Episode-based cost measures
  - a case minimum of 35 for MSPP
  - A case minimum of 20 for the total per capita cost measure

RESOURCES

QPP Home Page - https://qpp.cms.gov/

Participation Status toll - https://qpp.cms.gov/participation-lookup

QPP Measures page - QPP Measures Tool

Hardship application - Promoting Interoperability Hardship application

QPP COVID-19 FACT SHEET

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