MIPS

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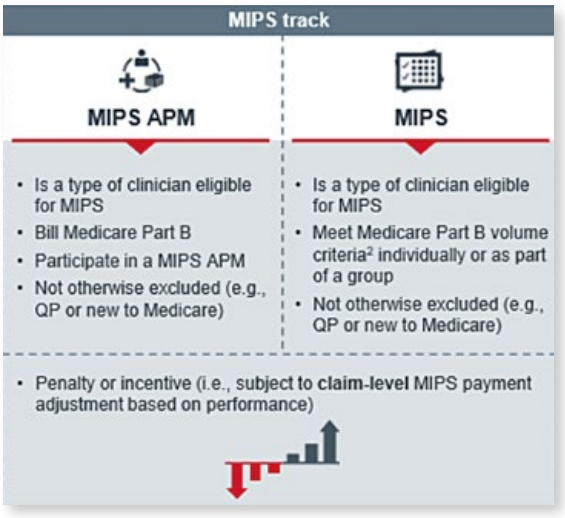
Participation, Performance Evaluation & Payment Adjustment Application for Payment Year 2019

As we have surpassed the midway point of the Merit-based Incentive Payment System's (MIPS) 2019 payment year, it is a great time to review this year's payment adjustments that resulted from the 2017 MIPS performance year reporting. Groups that participated as a MIPS-eligible practice earned bonuses or received penalties based on their 2017 MIPS activity, while others may have remained neutral. These payment adjustments were applied by CMS after applying its complex composite scoring methodology. Individuals and groups that exceeded the performance threshold of three points in the first "pick your pace" year of the program are beginning to receive MIPS payment adjustments on their CMS Medicare remittance advices.

When reviewing remittance advices for claims filed with dates of service after Jan. 1, 2019, it is important to properly record the MIPS adjustment in your practice management system. Note that these payment adjustments apply to all Medicare Part B professional covered services. The professional covered services include both the professional and technical component of claims billing as well as global claims billing. It is important



to note the payment adjustment does not apply to payments for Medicare Part B drugs or other items and services that are not covered professional services.

CMS has noted that patient copays and deductibles are not affected in any way by Quality Payment Program (QPP)/MIPS bonus or penalty, so don't add/subtract your adjustment amount to what the CMS Remittance Advice

Performance category and descriptions		Submit data to CMS?	MIPS APM weight	2019 MIPS weight[3]
Quality	*Clinical quality measures, like how well patients with diabetes achieve proper blood glucose control*	☑	50%	45%
Cost	*Claims data to compare how much services cost compared to benchmarks*	N/A	N/A	15%
IA	*Activities to encourage practice improvement, e.g., using disease registries*	☑	20%	15%
PI	*Assesses measures focused on use of certified EHRs; previously named ACI[1]/MU[2]*	☑	30%	25%

states the patient owes you. In an official QPP Fact Sheet on this subject, CMS notes: "The payment adjustment is applied to the Medicare paid amount, so it does not impact the portion of the payment that a beneficiary is responsible to pay."

Radiology groups are encouraged to pay close attention to the following new MIPS Remittance Advice (RA) codes for those claims with dates of service after Jan. 1, 2019. There are three code types CMS uses to communicate this information: (1) Claim Adjustment Reason Codes (CARCs), (2) Remittance Advice Remark Codes (RARCs), and (3) Group Code. (Please note: this third group code is used when a contractual agreement between the payor and payee, or a regulatory requirement, resulted in an adjustment.)

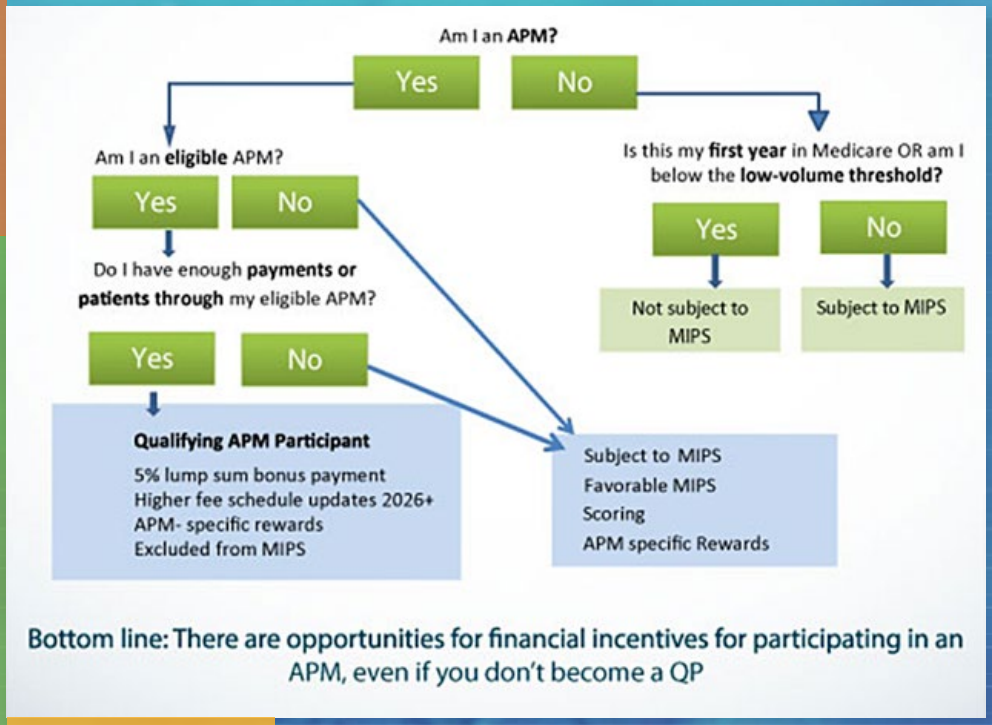
If you have achieved a positive adjustment, you will see the following line item and a corresponding amount: CARC 144 (incentive adjustment), RARC N807 (payment adjustment based on Merit-based Payment System [MIPS]), and "CO" for the Group code. Those receiving negative adjustments will instead see: CARC 237 (Legislated/Regulatory Penalty), as well as the N807 and CO codes, as stated above.

Beyond groups that roster MIPs EC's only, other groups may roster EC's that are tied to an Alternative Payment Model (APM) that may not meet the thresholds established to be a qualifying participant (QP) or partial qualifier in the Advanced APM track of the QPP. These MIPS eligible clinicians participate in the MIPS APM and have their performance evaluated according to the MIPS APM scoring standard, which weights the MIPS categories differently than the traditional MIPS scoring methodology. This MIPS APM scoring standard for PY 2019 weighs the Quality Performance category to 50 percent, Promoting Interoperability (PI) to 30 percent, Improvement Activity to 20 percent, and Cost to zero weight. This provides some advantages as these groups are subject to an improved scoring method under the MIPS APM reporting.

For groups who submitted data using their TIN identifier, the group's score will be applied to all MIPS eligible clinicians (TIN/NPI combinations) that billed under that TIN during each yearly performance period. For an APM Entity a score is assigned to all MIPS eligible clinicians participating in an APM Entity during the performance period. It's possible for more than one MIPS score to be associated with a single TIN/NPI combination. If an individual MIPS eligible

Qualifying Advanced APM Participant (QP)	Partially Qualifying Advanced APM Participant (PQ)	Neither a QP or PQ
• Receive 25% of their Medicare Part B payments through the Advanced APM, **OR** • See 20% of their Medicare Part B patients through the Advanced APM	• Receive 20% of their Medicare Part B payments through the Advanced APM, **OR** • See 10% of their Medicare Part B patients through the Advanced APM	• Receive less than 20% of their Medicare Part B payments through the Advanced APM, **AND** • See less than 10% of their Medicare Part B patients through the Advanced APM

Alternative Payment Model (APM)



clinician is a participant in a MIPS APM under a TIN/NPI and the group TIN reports to MIPS independently from the APM, then two scores (group and APM entity score) would be associated with the same TIN/NPI. However, only one MIPS score is assigned to each unique TIN/NPI combination to calculate and apply a MIPS payment adjustment for that specific TIN/NPI.

In the event that more than one score (MIPS, MIPS APM, or advanced APM) is associated with a single TIN/NPI combination, then the following hierarchy is used to assign one score to each MIPS eligible clinician's TIN/NPI combination:

- If a MIPS eligible clinician is a participant in a MIPS APM, then the APM entity score issued instead of any other score.
- If a MIPS eligible clinician received more than one APM entity score, then the highest APM entity score will be used.
- If a MIPS eligible clinician reported both as an individual and through a group and is not part of an APM entity, the higher of the two scores will be used.

Through the application of this MIPS hierarchy of scoring based on each TIN/NPI MIPS eligible clinician, subsequent payment adjustments would vary based on each individual providers APM status.

Providers within your group TIN may also be exempt from reporting to the MIPS track of the QPP program as a result of being a qualifying advanced APM participant. These QPs will automatically receive the five percent upward adjustment regardless if the QP is part of a group that submitted MIPS data on behalf of all the individual eligible clinicians in its group. Subsequently, providers within your groups TIN that are not QPs would receive the group or individual (higher of the two) payment adjustment this year (2019) achieved through 2017 MIPS-eligible reporting performance. These scenarios illustrate how payments are adjusted for TIN/NPI providers within a group that have different QPP eligibility.

REFERENCES

https://www.corcoranccg.com/news/pay-attention-remittance-advice-2019-claims-related-qppmips-payment-adjustments/

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-MIPS-Payment-Adjustment-Remittance-Advice-FAQs.pdf

https://www.advancedmd.com/learn/mips-payment-adjustment-codes/

https://www.advisory.com/research/quality-reporting-roundtable/events/webconferences/2019/macra-in-30-minutes/macra-201/ondemand

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