What is MIPS?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program for physicians and other eligible clinicians, referred to as the Quality Payment Program. This program rewards value and outcomes through the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs). MIPS combined the legacy programs (Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VM), Medicare EHR Incentive Program (EHR) for Eligible Professionals) into one program.

2018 MIPS – Quick Facts

- Year 2 begins January 1, 2018. Data must be submitted by March 31, 2019.
- Comprised of four performance categories (*Quality, Cost, Improvement Activities and Promoting Interoperability* (formerly Advancing Care Information). Cost performance will be calculated using administrative claims data.
- The minimum performance period for quality and cost is 12-months.
- The minimum performance period for Improvement Activities and Promoting Interoperability is 90-days.
- Points from each of the performance categories are added together for the MIPS Final Score.
- The MIPS Final Score is compared to the MIPS performance threshold to determine a positive, negative or neutral payment adjustment.
- The Performance Threshold is increased to 15 points to receive a neutral payment adjustment and the Payment Adjustment is now +/-5%.
- Exceptional performer is set at 70 points.

Participation

For the 2018 performance period there is no change in the types of clinicians eligible to participate in MIPS. MIPS eligible clinicians include:

- Certified registered nurse anesthetists
- Clinical Nurse Specialist
- Nurse Practitioners
- Physician Assistants
- Physicians

Exclusion

- Newly-enrolled in Medicare during the performance period
- Below the **low- volume threshold**
- Significantly participating in Advanced APMs

Eligibility

The *Low Volume Threshold* to participate in MIPS is: eligible clinicians billing more than **$90,000** a year in Medicare Part B allowed charges **AND** providing care for more than **200** Medicare patients a year.

Achieving the 15-point Threshold

- Submit (6) Quality measures that meet data completeness.
- Report all required Improvement Activities.
- Meet the Promoting Interoperability base score and submit (1) Quality Measure that meets data completeness.
- Meet the Promoting Interoperability base score and submit (1) medium-weighted Improvement Activity.