Healthcare's Risky Business - A Guide to Provider Success in the MIPS World of Quality & Risk

Daria Bonner, CHCRA, CHCA, CCP, RMC

Remember the good ole days when all providers needed only to worry about getting paid for the services rendered based on their contracted rates spelled out in a mutual agreement between a doctor, their patient, and the insurance company of the patient's choice? Yes, providers may have struggled with the concepts of medical necessity and bundling edit denials, but generally payment was made when the services were rendered and clinical decision making was reserved for the provider and patient to work out without a middle man directing the traffic. Those days are but a memory now as the effort to contain healthcare costs becomes the central focus in the delivery of care, the quality of the care provided and the costs associated with providing that care.

While these models have been utilized in the hospital inpatient and outpatient settings for some time now, the models are new territory for providers in the professional setting. In this world of "measurements", it is not just the provider and patient that share in the decision-making process anymore. Insurance companies, in an effort to cut costs and ensure the necessity of services provided, have established various healthcare payment reform models in the professional setting and these models are changing rapidly from year to year. Providers barely have time to catch up before a new rule, regulation, or guideline presents yet another challenge in the name of "risk", and "quality" as it relates to patient care.

So how can providers establish a foundation to ensure that their risk is minimized without impacting the quality of care to their patients? It's all about having a better understanding of these quality and risk models, how to document appropriately the conditions and treatment plan for care of the patient, and how to accurately report documented services in the form of CPT, HCPCS and ICD10CM coding systems.

While there are a number of quality and risk models that are changing the way providers track quality of care and risk of patient populations they are treating, the one model that has made the most impact in both quality and risk that continues to make the most substantial changes year to year in the professional setting is the Merit-based Incentive Payment System (MIPS).

Merit-based Incentive Payment Program for Professional Services

The Merit-based Incentive Payment System, better known as MIPS, is a quality payment program mandated by the Medicare Access and CHIP Reauthorization Act of 2015.

The law repealed the Sustainable Growth Rate formula established in the Balanced Budget Act, merged various quality programs already existing into one quality program (MIPS), created a new alternative payment models that provides bonus payments for eligible providers, and required removal of social security numbers from Medicare insurance cards. The law mandated that CMS create a quality payment program that focuses on rewarding value and outcomes of patient care.

The fee-for-service model still exists as the method for paying providers, however, MIPS eliminates automatic across the board annual increases to provider fees. Under MIPS, provider fees will be increased, decreased, or remain the same based on individual provider MIPS scores reported in previous years. The goal of MIPS is to focus less on paying for quantity of services provided and more on the quality and cost-efficiency of the care provided. In addition, the program encourages practices to improve processes and health outcomes and increase the use of electronic healthcare information among various providers in an effort to reduce the cost of the delivery of healthcare provided to patients.

MIPS

Quality

Improvement Activities

Advancing Care Information

Cost
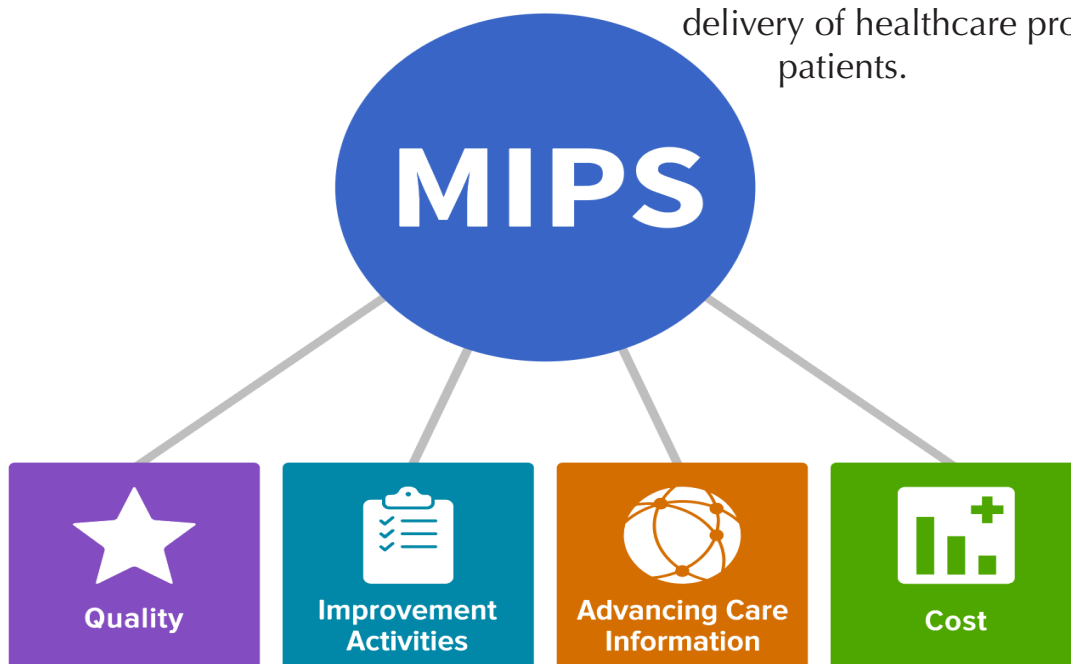
There are four performance categories that MIPS utilizes to determine whether the provider receives a negative, positive, or neutral (none) adjustment to their fee schedule; Quality, Promoting Interoperability, Improvement Activities, and Cost.

MIPS Quality Performance Category

The Quality performance category is not a new concept in tracking quality of care for professional
services. The quality care category replaces the previous Physician Quality Reporting System (PQRS)
program developed by CMS in 2006.

MIPS Promoting Interoperability Category

Like the Quality category, the Promoting Interoperability performance category is not a new program to CMS. This performance category replaced the Medicare Meaningful Use program first developed as part of the American Reinvestment & Recovery Act (ARRA) included in the "Health Information Technology for Economic and Clinical Health (HITECH) Act" designed by CMS and Office of the National Coordinator for Health IT (ONC) to promote the use and sharing of electronic medical record between providers and patients in an effort to coordinate care of the patient.

MIPS Improvement Activities Category

The Improvement Activities performance category is a new quality program designed exclusively as part of MIPS. The activities focus on physician and patient collaboration including processes for improving patient care, development of processes to encourage patient participation in care (i.e.

patient medication risk assessment) and improvement to access of care for patients within the practice.

MIPS Cost Category

The Cost performance category is not a new category under MIPS. The Cost category under MIPS replaces the previous CMS quality Value Modifier (VM) program. The Cost category measures the quality and cost of care provided to people who are insured by Medicare with payments made under the Medicare Physician Fee Schedule (PFS). The Cost program category utilizes the HCC Risk Adjustment scoring system to determine cost for services rendered. Data is retrieved from claims submitted to the Medicare program.

MIPS Program & Development Plan

It is important to develop and implement an effective MIPS program so that your practice is able to receive increases in your annual fee schedule. It is critical that the following areas be assessed annually to ensure compliance and obtain the increases in your Medicare fees that you deserve.

1. Check and recheck your eligibility for each provider annually.

2. Determine whether your providers will report as a group or individually.

3. Be sure to perform an annual assessment of your EHR to ensure that they meet all requirements of the MIPS program year and that they are certified and able to submit MIPS documentation effectively
and accurately.

4. In an effort to receive the highest number of points and receive an increase to your fee schedule, be sure to report the maximum amount of time required for collecting Quality and Cost measures (entire year) and the Promoting Interoperability and Improve Activity categories (minimum of 90 days).

5. Select the measures for the reporting period for each category of MIPS. The overall scores for the categories for data collected in 2019 are listed below.
• Quality Measures - 45%;
• Promoting Interoperability Measures - 25%;
• Improvement Activities Measures - 15%; and
• Cost - 15%

6. Assess MIPS Program HIPAA compliance and risk as it relates to the security of patient data in the practice.

7. Develop processes and procedures to ensure MIPS program and data collection efforts are adequate.

8. Develop, track and monitor reports to measure success of MIPS program within the practice.

9. Be sure to create a manual and electronic version of the data collected for each category and keep in a secure safe place. Note all MIPS data must be kept for a minimum of 6 years before purging.

10. Be sure to submit all collected category data by the submission date. The 2019 submission deadline is the first quarter following the performance year, which is January 1 to March 31, 2020.

While quality and risk models in the healthcare professional setting today are a relatively new concept, the means of ensuring compliance with these new models is no different than it has ever been under the previous fee-for-service models we have maintained for decades. The keys to successful successfully developing and implementing a MIPS program in any practice is to ensure providers and staff understand the key requirements of the MIPS program, that services rendered are documented appropriately by the eligible MIPS providers , that the CPT, HCPCS Level II and ICD-10-CM codes reflect the highest level of specificity that is documented, and that continuing education and training is provided to everyone in the practice. Following these TIPS will ensure that your practice will be successful with MIPS!

If you need assistance developing, implementing and/or monitoring your MIPS program, contact Daria Bonner by email at dbonner@xacthealthcaresolutions.com or visit our website at www.xacthealthcaresolutions.com for more information on our services.