Submission Mechanisms for the Merit-Based Incentive Payment System (MIPS)

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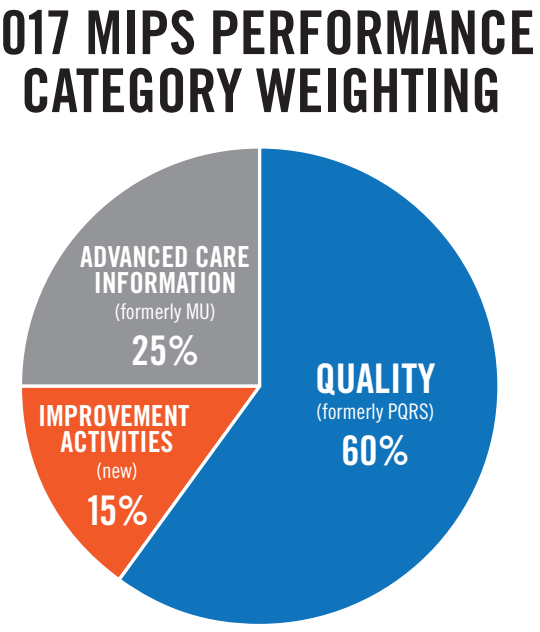
With over 9 years of experience as a CMS registry and well over 10 years supporting providers and group practices with various pay-for-performance program reporting, we have heard an overabundance of unfortunate accounts where clinicians and/or practices using other organizations were misled or misinformed in choosing their submission mechanism. The regrettable consequences of these missteps include: massive revenue losses both from penalties and potential bonus payments, lost dedicated clinical visit time, clinician and staffing toil working with complicated data and systems, and in some cases government auditing, among multiple other aggravations. Typically, by the time clinicians and practices identify a problem with their submission mechanism, it is either too late to make corrections or it requires unplanned and extensive staffing, resources, and over-time hours to mitigate the unforeseen submission error(s). To avoid such disaster, it is critical that clinicians and group practices understand all elements involved with choosing the right submission mechanism for all pay-for-performance program reporting.

One of the main pay-for-performance programs clinicians and group practices are currently working on or working to understand is the Merit-Based Incentive Payment System (MIPS). The MIPS program is one of two tracks in the Quality Payment Program, which was born out of the Medicare Access and CHIP Reauthorization Act of 2015. The first performance period under the MIPS program is January 1, 2017 to December 31, 2017. The MIPS program streamlined three pay-for-performance programs into one and added an additional subject, which is intended to promote continuous improvement. Figure 1 below shows the 3 weighted categories under the MIPS program and the pay-for-performance program each one originated from.

Figure 1:



- **Quality**, formerly part of the Physician Quality Reporting System (PQRS)
- **Cost***, formerly part of the Value-Based Payment Model (VM) (*weighted to zero for 2017)
- **Advancing Care Information (ACI)**, formerly the Meaningful Use program
- • **Improvement Activities (IA)**, new

When first approaching the subject of how to submit data for each performance category under the MIPS program, it should first be decided at what aggregation level you plan to report, group or individual. MIPS eligible clinicians and group practices have the choice to report at either the individual provider or the group (or Tax ID Number) level. Both options have advantages and disadvantages. Whichever aggregation level is chosen will be the aggregation level reported for all categories under the MIPS program. It is not an option to report one category at the group level and another at the individual clinician level.

There are several mechanisms for submission of data for each performance category under the MIPS program. Figure 2 below shows the different submission method options for reporting each performance category at either the individual or group level.

Figure 2:

MIPS Category	Individual Reporting	Group Reporting
Quality	Qualified Registry QCDR (Qualified Clinical Data Registry) EHR Claims	Qualified Registry QCDR (Qualified Clinical Data Registry) EHR Administrative Claims CMS Web Interface (25+ providers) CAHPS for MIPS Survey
Improvement Activities (IA)	Qualified Registry QCDR Attestation EHR Vendor	Qualified Registry QCDR Attestation EHR Vendor CMS Web Interface (25+ Providers)
Advancing Care Information (ACI)	Attestation Qualified Registry QCDR EHR Vendor	Attestation Qualified Registry QCDR EHR Vendor CMS Web Interface (25+ Providers)

Qualified registry reporting grew in popularity by the 2015 PQRS performance year, especially given the higher accuracy rates that registry reporting held over claims reporting. Roughly 12% of eligible professionals who participated in 2015 PQRS reporting, reported using the qualified registry method of reporting2. Qualified registry submission involves contracting with a 3rd party vendor who typically supports the MIPS eligible clinicians or group practice with program guidance along with reporting and submission tools. Qualified registry reporting is an option for reporting all three performance categories at both the individual or group aggregated levels. When choosing a registry, it is recommended that MIPS eligible clinicians and groups confirm that the registry supports all measures that the clinician or group plans to use for reporting.

Qualified Clinical Data Registry (QCDR) reporting also grew in popularity by the 2015 PQRS performance year. QCDR reporting jumped from 3274 eligible professionals in 2014 to 15,381 in 20152. A QCDR is a CMS-approved entity, such as a specialty society, certification board, or regional health collaborative that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. The QCDR method of reporting is an option for all three performance categories at both the individual or group aggregated levels. Some QCDRs are specifically focused on a certain specialty and therefore only offer a short list of measures associated with that specialty. Additionally, some QCDRs do not offer certified EHR technology (CEHRT) and therefore cannot report on the electronic clinical quality measures (eCQMs). When choosing a QCDR, it is recommended that MIPS eligible clinicians and group practices ensure a QCDR offers the measures and the reporting mechanisms they will need for reporting under MIPS.

Electronic Health Record (EHR) reporting also showed some popularity growth in the 2015 PQRS reporting year with a 12% increase from 2014 participation2. Even considering the increased rate of EHR reporting, only about 57,000 professionals reported through their EHR equating to roughly 6% of eligible professionals who participated in 2015 PQRS reporting. EHR reporting is an option for reporting all three performance categories at both the individual and group aggregated levels, however, it also depends on what reporting capabilities are offered by your EHR. Some EHRs are specialty-based and therefore would only offer measures related to that specific specialty. Some EHRs may not have completed their ONC certification to become a CEHRT and therefore would not be able to report on the eCQMs. It is recommended that MIPS eligible clinicians and group practices work with their EHRs to determine their offerings for each category under the MIPS program.

The claims method of reporting continued to be the most common method of reporting under the Physician Quality Reporting System (PQRS) in 2015 . Roughly 35% of eligible professionals who participated in 2015 PQRS reporting, reported using the claims method but only 4% satisfactorily reported on 9 measures, which was the minimum reporting requirement for that reporting year2. The claims method of reporting involves MIPS eligible clinicians adding a Quality Data Code (QDC) onto each Medicare claim, which represents the quality action(s) taken according to the given measures being reported. As shown in Figure 2 above, the claims method of reporting is only available for reporting the Quality performance category under the MIPS program and only at the individual clinician level. Group level reporting using claims is not a currently supported method of reporting.

[1]United States. Center for Medicare and Medicaid Services. 2016 Physician Quality Reporting System (PQRS): Qualified Clinical Data Registry (QCDR) Participation Made Simple. October 2016. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016PQRS_QCDR_MadeSimple.pdf

Some MIPS group practices of 25 or more that registered with CMS by June 30th, 2017 will report using the CMS web-interface system for the MIPS category. Those groups will report on any or all of the following:

- For quality, 15 CMS web-interface measures
- For ACI, at least 90 days of the CEHRT measures
- For Improvement Activities, at least 90 days of improvement activities

In prior years, the web-interface option had only been offered for ACO program reporting as well as for the PQRS program. The web-interface method of reporting had previously been considered a more manual method requiring those entering data to do so one patient at a time. Under the MIPS program, CMS has not only expanded the web-interface to include ACI and IA reporting but has also added the ability to upload XML files, which is expected to improve the historically manual efforts using this submission mechanism.

Some MIPS group practices who also registered with CMS by June 30th, 2017 will report on the CAHPS for MIPS survey measures. The CAHPS for MIPS survey measures count for one high-priority measure under the Quality performance category. MIPS group practices need to contract with a certified survey vendor to submit survey data based on a sampling pool of Medicare Part B patients. CAHPS for MIPS reporting must be paired with another reporting mechanism to satisfactorily report for an incentive under the MIPS program in 2017.

The final and most manual option for submission of MIPS data is attestation. Attestation is the method EHR Incentive Program clinicians and practices previously used to enter their Meaningful Use data. Attestation is an option for reporting the Improvement Activities and the ACI performance categories at both the individual and group aggregated levels. Those using the attestation method would sign into a CMS secure website and enter the information for the performance category they are choosing to report.

Choosing the right submission mechanism requires research and understanding of all the elements needed to successfully submit data. Clinicians and group practices should understand the costs, resources, timing constraints, and system requirements needed to successfully use the chosen submission mechanism. Take into account the following tips when deciding on a submission mechanism:

- For registry, QCDR, and EHR submission, make sure the selected option supports all measures and meets all certification criteria to successfully submit data for your chosen performance categories

- For claims submission, make sure your clinicians and office staff understand all current measures specifications, including the correct QDCs needed to correctly and satisfactorily report on the Quality category

    a. Additionally, make sure you couple the claims mechanism with all other necessary mechanisms to satisfactorily report on all categories under the MIPS program

- For web-interface, CAHPS for MIPS, and attestation reporting, make sure you have the staffing and resources available at the time of reporting (in case you are lacking the XML file generation skillset needed for web interface XML file uploading and therefore need to manually input data for all patients for all measures) as well as any other needed mechanism to fulfill all MIPS category submission

Understanding the full life-cycle of submission according to your chosen submission mechanism is critical to understand what resources will be necessary to fulfill all reporting requirements. Staying prepared for each phase of submission will minimize disaster and allow clinicians and group practices to focus on patient care and outcomes management, which is the primary goal of these pay-for-performance programs.

[2]United States. Center for Medicare and Medicaid Services. 2015 Reporting Experience Including Trends (2007-2015): Physician Quality Reporting System. 2017. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_Experience_Report.pdf