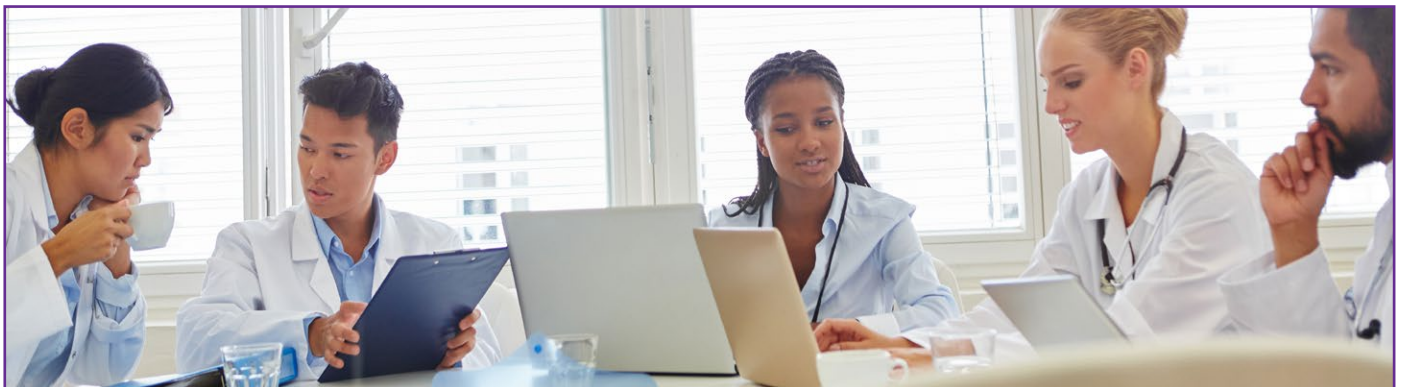# How to select the best MIPS data submission method for your practice or group

Under MACRA's* Quality Payment Program, the Merit-Based Incentive Payment System (MIPS) reporting period begins January 1, 2018. Health care clinicians across the country must decide which MIPS data submission method best suits their practice or group.

At first glance, choosing a 2017 MIPS data reporting method may seem like a simple task. However, a closer look at the thresholds and requirements of each reporting option can mean the difference between receiving a negative or positive payment adjustment from Medicare.

2017 MIPS Submission Considerations – What is your end goal?

As implied in Lewis Carroll's famous quote, "If you don't know where you're going, any road will get you there," it is wise to begin with your end goal in mind. Here are a few questions to ask yourself before arriving at a decision:

- Do you want to report the minimum necessary data to avoid a penalty or are you setting up your processes in 2017 for maximum payment reimbursement in 2019 and beyond?

- Do you want the flexibility to choose and report all relevant categories and measures that best reflect your group or practice's performance?

* Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

The chart below will help you understand the main components for each of the 2017 MIPS data submission methods and decide which submission method best complements your organization's end goal.

MIPS Submission Methods for 2017 Performance Data

Submission Method	Submission Method Eligibility	2017 Reportable Measures	Reporting Period Requirement	Data Requirements	
Administrative Claims	Individual MIPS eligible clinicians	1	A minimum of one continuous 90-day period during CY2017	50% of a clinician's MIPS-eligible Medicare Part B patients for the performance period	For Quality measure: No submission required for the all-cause hospital readmission measure
Electronic Health Record (EHR)	Individual MIPS-eligible clinicians or groups	53	A minimum of one continuous 90-day period during CY2017	50% of a clinician's MIPS-eligible or patient groups across all payors for the performance period	
Qualified Clinical Data Registries (QCDR)	Individual MIPS-eligible clinicians or groups	243	A minimum of one continuous 90-day period during CY2017	50% of a clinician's MIPS-eligible or patient groups across all payors for the performance period	Not limited to Medicare patient data; can host "non-MIPS" measures approved by CMS for reporting
Qualified Registry (such as nThrive)	Individual MIPS-eligible clinicians or groups	243	A minimum of one continuous 90-day period during CY2017	50% of a clinician's MIPS-eligible or patient groups across all payors for the performance period	If specialty set has less than six measures available, report all to avoid negative impact
CAHPS for MIPS Reporting Survey Vendor	MIPS-eligible clinician groups only	Entire survey must be completed	Full calendar year: 1/1/2017 through 12/31/17	Entire survey must be completed	For Quality measure: CMS-approved survey vendor providing CAHPS for MIPS (must be reported in conjunction with another data submission mechanism)
CMS Web Interface	MIPS-eligible clinician groups of 25 or more only	15 (all are required)	Full calendar year: 1/1/2017 through 12/31/17	The first 248 eligible visits for a clinician's Medicare Part B patients	

NOTE: Must register as a group with the Centers for Medicare and Medicaid Services (CMS) before June 30, 2017

The 30-day All-Cause Hospital Readmission measure (ACR) is a risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized at a shortstay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge. The measure applies to solo practitioners and practitioner groups, as identified by their Taxpayer Identification Number (TIN).

The transition to the MACRA Quality Payment Program is complicated and nThrive is here to help. We deliver the advisory services, on-demand education and technology necessary to thrive under the Quality Payment Program.

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