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**Topic:** Merit-based Incentive Payment System (MIPS) FAQs

**Date:** February 6, 2017

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## MERIT- BASED INCENTIVE PAYMENT SYSTEM (MIPS) FAQs

### What is MIPS?

The **Merit-based Incentive Payment System (MIPS)** is part of the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP) and is the next evolution of three quality programs: Meaningful Use of electronic health records (EHR), the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier (VM). The Quality Payment Program reforms Medicare by receiving and validating physician-submitted data, providing performance feedback, determining MIPS scores, and adjusting payments.

MIPS will focus on four categories, assigning providers a composite score based on their performance and will serve as a modifier on their Medicare Part B reimbursements. The categories are:

- Quality (formerly PQRS)
- Resource Use/Cost (formerly VM)
- Clinical Practice Improvement Activities (CPIA; a new category)
- Advancing care information (Meaningful use of a certified EHR)

MIPS will assess the total performance of each MIPS eligible clinician (EC) according to performance standards for a year.

### What is MACRA?

MACRA stands for the Medicare Access and CHIP Reauthorization Act of 2015. MACRA repealed the broken Medicare sustainable growth rate formula and reformed Medicare's reimbursement system with two new payment pathways for physicians: the MIPS and Alternate Payment Models.

### What do pathologists need to know about MIPS in 2017?

Pathologists must take action in 2017 in order to stop their Medicare payments from being cut in 2019. The CMS will use the 2017 calendar year as a performance period to determine whether or not physicians and group practices will face penalties of up to 4% in 2019. Individual pathologists or group practices can stop the penalty by reporting at least one quality measure in 2017.

The CAP has developed eight quality reporting measures specifically for pathologists—helping CAP members avoid tens of millions of dollars in Medicare penalties every year. The CAP has secured the inclusion of these measures in the MIPS program.

### Is there an opportunity to earn a bonus in MIPS?

Yes. The CMS outlined four tracks for MIPS in 2017. One track allows physicians to simply stop the penalty, while two other tracks offer the opportunity to increase Medicare reimbursements in 2019. The tracks are:



- **Test MIPS:** If you submit a minimum amount of 2017 data to CMS (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment in 2019. [Here](#) is a list of the eight pathology quality measures and a list of the Improvement Activities ([see attachment](#)) that may be applicable to pathologists.
- **Partial Year Reporting:** If you submit quality data to Medicare for 90 days in 2017 you may earn a neutral or small positive payment adjustment. You are eligible to earn up to 4% positive payment adjustment in 2019.
- **Full Year Reporting:** If you submit a full year of 2017 data to Medicare, you may earn a moderate to the full 4% positive payment adjustment.
- **Don't Participate:** If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

In future years, a MIPS EC would receive no payment adjustment if the performance score is at the performance threshold, a negative adjustment if the score is below the performance threshold, and a positive adjustment if the score is above the performance threshold.

Beginning in 2019 physicians can earn Medicare bonuses of up to 4% in MIPS. At the same time, the maximum penalty for non-participation in MIPS could reduce Medicare pay by 4% in 2019.

#### **Is there anything that will affect which reporting requirements and performance metrics apply to pathologists?**

The CMS recently published a list of patient-facing encounter codes that will affect which reporting requirements and performance metrics apply to clinicians within MIPS.

The CAP did an analysis of current members to differentiate members that are patient-facing. From the CAP's analysis, although about 400 pathologists might bill for codes in the list, only about 50 pathologists would meet the definition of patient-facing eligible clinicians, i.e., bill greater than 100 patient-facing encounters.

The CAP will continue to monitor as the CMS sends notifications to eligible clinicians to inform them of their patient-facing status. We will also continue to ask that the CMS classify pathologists as non-patient facing eligible clinicians based on the PECOS-physician enrollment code.

#### **How do I Avoid a MIPS Penalty in 2019?**

In order to avoid penalties in 2019, practices must submit quality reporting data for 2017 no later than March 31, 2018. By submitting data on one quality measure, a physician can stop the Medicare penalty. A physician can also attest to participating in a clinical practice improvement activity to stop the penalty. The CMS has not yet provided details on attestation but the CAP will keep members updated.

#### **How can I get a positive adjustment in 2019?**

Successful participation for non-patient facing ECs is defined as reporting on 50% of patients on six measures including one outcome measure and report on two medium or one high CPIA. For claims-based reporting, only Medicare patients are counted, for all other reporting mechanisms the requirement is to report on 50% of all patients for which the measure applies. Those who successfully report for 90 days may be eligible for a small bonus and those who report for the full year may be eligible for the full 4% positive adjustment.



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### **How do I submit data to receive payment?**

There are three options to submit your MIPS data:

- 1) Through an electronic health record or registry
- 2) Qualified registry or Qualified clinical data registry (QCDR)
- 3) Send in quality data through your routine Medicare claims process.

If you send MIPS data in as an individual, your payment adjustment will be based on your performance. If you send your MIPS data with a group, the group will get one payment adjustment based on the group's performance.

### **What is the timeline to submit date for MIPS and payments?**

The performance period started on January 1, 2017 and closes December 31, 2017.

To potentially earn a positive payment adjustment under MIPS, the CMS must receive data before **March 31, 2018**, although practically the date is earlier for registry reporting as registries will need time to process the data. Those reporting by claims must report at the time of billing, and registries typically will need the data by January 31, 2018 to process the information.

The first payment adjustments based on performance go into effect on January 1, 2019.

For more information about the program, please check out the [CAP infographic](#) or <https://qpp.cms.gov/>.

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## ATTACHMENT - IMPROVEMENT ACTIVITIES

### CPIA that are likely applicable to pathologists (from Table H, MACRA Final Rule)

#### **Subcategory: Expanded Practice Access**

Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following:

- Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care);
- Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or
- Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.

Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults, or teleaudiology pilots that assess ability to still deliver quality care to patients.

#### **Subcategory: Care Coordination**

Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the certified EHR technology.

Timely communication of test results defined as timely.

Establish standard operations to manage transitions of care that could include one or more of the following:

- Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or
- Partner with community or hospital-based transitional care services.

#### **Subcategory: Patient Safety and Practice Assessment**

Participation in Maintenance of Certification Part IV for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program.

Performance of activities across practice to regularly assess performance in practice, by reviewing outcomes addressing identified areas for improvement and evaluating the results.

- Use of tools that assist specialty practices in tracking specific measures that are meaningful to their practice, such as use of the Surgical Risk Calculator.
- Participation in Joint Commission Ongoing Professional Practice Evaluation initiative.
- Participation in other quality improvement programs such as Bridges to Excellence.

Implementation of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions (URI Rx in children, diagnosis of pharyngitis, Bronchitis Rx in adults) according to clinical guidelines for diagnostics and therapeutics.



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Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following:

- Train all staff in quality improvement methods;
- Integrate practice change/quality improvement into staff duties;
- Engage all staff in identifying and testing practices changes;
- Designate regular team meetings to review data and plan improvement cycles;
- Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or
- Promote transparency and engage patients and families by sharing practice level quality of care, patient