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

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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 focuses 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)
- **Cost** (formerly VM)
- **Improvement Activities (IA)**; a new category)
- **Promoting Interoperability** (formerly Advancing Care Information/Meaningful Use of a certified EHR)

MIPS will assess the total performance of each MIPS eligible clinician 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 MACRA repealed the broken Medicare sustainable growth rate formula and reformed Medicare's reimbursement system with two new payment pathways for physicians: the MIPS and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 2018?**

2018 is the second year of MIPS reporting for the CMS. Pathologists must take action in 2018 in order to stop their Medicare payments from being cut in 2020. The CMS will use the 2018 calendar year as a performance period to determine whether or not physicians and group practices will face penalties of up to 5% in 2020.

The CAP has helped members avoid tens of millions of dollars in Medicare penalties every year through development of pathology-specific quality measures (e.g. PQRS). The CAP has secured the inclusion of these measures in the MIPS program in addition to developing the Pathologists Quality Registry providing pathologists with even more pathology-specific quality measures.

**Is there an opportunity to earn an incentive in MIPS in 2020 by reporting in 2018?**

Yes. In order to earn the maximum incentive, pathologists must report on six quality measures for at least 60% of their eligible patients for a full year. They must also report on one high-weighted or two medium-weighted Improvement Activities. The CAP has identified a list of [Improvement Activities](#) most likely relevant to pathology.



A MIPS eligible clinician will receive neither an incentive nor a penalty if their performance score is at the performance threshold of 15, a negative adjustment if their score is below the performance threshold and an incentive if their score is above the performance threshold.

By fulfilling 2018 MIPS requirements, physicians can earn Medicare incentives of up to 5% in 2020 through the MIPS program. At the same time, the maximum penalty for non-participation in MIPS during the 2018 performance period could reduce Medicare payments by 5% in 2020.

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

The CMS 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 who are patient-facing. From the CAP 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.

### **How do I avoid a MIPS Penalty in 2020?**

In order to avoid penalties in 2020, practices must submit data for 2018 **no later than March 31, 2019** and score above the performance threshold of 15 points.

Pathologists can achieve this in a number of ways. For example, by submitting data on six quality measures, a physician can stop the Medicare penalty. A physician can also attest to participating in a high-weighted Improvement Activity to earn 15 points and stop the penalty.

### **How can I earn an incentive in 2020?**

Successful MIPS participation for non-patient facing eligible clinicians is defined as reporting on 60% of patients on six measures including one outcome measure and report on two medium or one high IA.

For claims-based quality reporting, only Medicare patient data is accepted, for all other reporting mechanisms the requirement is to report on 60% of all patients for which the measure applies.

Those who successfully report for the full year may be eligible for the full 5% incentive.

### **Can I report on the Promoting Interoperability (formerly Advancing Care Information) category even though I am a non-patient facing pathologist?**

Yes. Even though your Promoting Interoperability (PI) score is automatically reweighted to the Quality category if you are non-patient facing, you can still submit PI data to CMS. The CMS will score you on all data submitted, so there is no formal “opt-in” process. If you choose to also submit PI data, your MIPS score will be based on the following weights:

- **Quality – 60%**
- **Promoting Interoperability (PI) – 25%**
- **Improvement Activities (IA) – 15%**

The PI category assigns credit for use of a Certified Electronic Health Record Technology (CEHRT) and reporting of EHR-specific measures. These are the requirements for PI reporting:



1. **An LIS that is 2014 or 2015 CEHRT edition**
  - a. **Report on base measures to receive 50% base score. If these requirements are not met, you will get a 0 in the overall Promoting Interoperability category score.**
2. **Report on performance measures to receive a performance score**

You can learn more about this category and its measures [here](#).

### **How do I submit data to comply with 2018 MIPS reporting requirements?**

There are four 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\*.
- 4) Attest to an Improvement Activity (IA) via a registry or the CMS portal.

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.

*\*Note: claims-based reporting cannot be used for attestation of Improvement Activities*

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

The 2018 MIPS performance period started on January 1, 2018 and closes December 31, 2018.

To potentially earn an incentive under MIPS, the CMS must receive 2018 performance data before March 31, 2019, 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 2018 performance data submitted by January 31, 2019 to process the information.

The payment adjustments based on 2018 performance go into effect on January 1, 2020.

### **Did the CMS make MIPS eligibility changes for small practices?**

To reduce burdens on small practices, the CMS changed the eligibility threshold for 2018 to make more small practices and clinicians exempt from reporting. Therefore, if you were not exempt from MIPS in 2017, you may now be exempt from reporting this year. It is beneficial to check your eligibility again for 2018.

Based on the 2018 regulation, clinicians and groups are now excluded from MIPS reporting if they:

- Billed \$90,000 or less in Medicare Part B allowed charges for covered professional services under the Physician Fee Schedule (PFS), or
- Furnished covered professional services under the PFS to 200 or fewer Medicare Part B-enrolled beneficiaries

To be included in MIPS for the 2018 performance period, you need to have billed more than \$90,000 in Medicare Part B allowed charges for covered professional services AND furnished services to more than 200 Medicare Part B enrolled beneficiaries.

### **Are Locum tenens exempt from MIPS? Do pathology practices that use Locum tenens still report on their cases?**



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Locum tenens clinicians bill for the items and services they furnish using the National Provider Identifier number (NPI) of the clinician for whom they are substituting, therefore they do not bill Medicare in their own right for the items and services they furnish. Therefore locum tenens clinicians are not MIPS eligible clinicians. The cases seen by the locum tenens would be attributed back to the NPI for the clinicians they were covering.

**If a practice has 10 pathologists and only 4 of them are eligible for MIPS, if they choose to do Group Reporting, do all 10 pathologists need to be included in the Group or can it simply just be the 4 who are eligible for MIPS? If the answer is that all 10 pathologists should be included in the Group Reporting, do all 10 receive a MIPS bonus or would the MIPS bonus only be applied to the 4 who are actually eligible for the MIPS program?**

If the practice chooses to report as a group, they will need to submit data for all clinicians reporting under their Taxpayer Identification Number or TIN, even those who would have been exempt as individuals. Therefore, all 10 pathologists would need to report under one TIN. Therefore the payment adjustment would apply to those who would have been excluded due to low volume threshold at the individual level, but not to those who would have been excluded because they are newly enrolled in Medicare or are qualified participants in an APM.

For more information about the program, please check out <https://qpp.cms.gov/> or email [registry.inquiries@cap.org](mailto:registry.inquiries@cap.org)