MIPS in 2019: An Overview Of What Has Changed

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Welcome

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• Vice Chair, CAP Council on Government and Professional Affairs
• Chair of the CAP Clinical Data Registry Ad-Hoc Committee
Today

- Quality Payment Program (QPP) Overview
- 2019 MIPS Implementation: Year 3
- Quality Category Scoring
- Pathology-Specific Quality Measures
- Medicare Part B Claims Submission Method
- Facility-Based Scoring
- Check Your 2019 MIPS Eligibility
Quality Payment Program Pathways

QPP

MIPS

Advanced APMs

Quality, Improvement Activities, Promoting Interoperability, Cost
Year 3 MIPS Implementation: Increased Performance Thresholds

Performance Year 2019: The CMS increased the Performance Threshold to **30 points**, and the Exceptional Performance Bonus Threshold to **75 points**

Payment Year 2017 2018 2019 2020 2021 2022 2023 2024

Minimum Score: If your total MIPS score is not at **least 30 points in 2019**, you are subject to a penalty.
Low Volume Threshold Expansion + Opt-In

• **Third Criterion Added** to expand eligibility for low volume threshold:
  o To be excluded from MIPS, clinicians or groups would need to meet one of the following three criteria:
    • \( \leq \$90K \) in Part B allowed charges for covered professional services
    • Provide care to \( \leq 200 \) beneficiaries
    • Provide \( \leq 200 \) covered professional services under the Physician Fee Schedule (PFS)

• **New opt-in participation for low volume practices:**
  o Starting in Year 3, clinicians or groups would be able to opt-in to MIPS if they meet or exceed one or two, but not all, of the low-volume threshold criterion
Category Weights for Non-Patient Facing Pathologists Remain the Same

- **Quality Measures**: Score out of 85 points
- **Improvement Activities**: Score out of 15 points
  - 90 days reporting
  - Attest to 1 high-weighted or 2 medium-weighted
- **Promoting Interoperability**: Re-weighted to Quality
- **Cost**: 8 new episode-based cost measures
  - Not applicable to pathologists
Reporting Requirements for Quality Measures

• Report a minimum of 6 measures
  o One must be an outcome or high priority measure
    – Bonus points for each additional
  o 12-month reporting period
  o 60% data completeness
  o 20 case minimum per measure

• Small practices: 6 bonus points added to Quality category score
Measure Scoring Remains the Same

• Measure value

<table>
<thead>
<tr>
<th>Max Points</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>With benchmark</td>
</tr>
<tr>
<td>7</td>
<td>Topped-out for 2 consecutive years</td>
</tr>
<tr>
<td>3</td>
<td>Without benchmark</td>
</tr>
</tbody>
</table>

• Submitting below 20 case minimum, score capped at 3 points regardless of practice size

• Don’t meet 60% data completeness

<table>
<thead>
<tr>
<th>Points</th>
<th>Practice Size</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Large Practice (16+ pathologists)</td>
</tr>
<tr>
<td>3</td>
<td>Small practice (≤15 pathologists)</td>
</tr>
</tbody>
</table>
CMS Meaningful Measures Initiative

- **69%** of claims-based measures are topped out, and are being phased out
- **New CMS policy for extremely topped out measures (defined as 98-100% performance)**
  - CMS will retire extremely topped out measures
  - Will not follow 4-year lifecycle applicable to other topped-out measures
- **The CMS finalized the removal of the following three of the eight CAP-developed QPP measures identified as extremely topped out:**
  - Breast Cancer Resection Reporting
  - Colon Cancer Resection Reporting
  - Quantitative IHC Evaluation of HER2 Testing in Breast Cancer Patients
Where do the CAP’s QPP Measures Stand?

• Remaining five CAP QPP measures
  o Most are topped out for 2 consecutive years
  o Score capped at 7 points

• Two additional QPP registry measures
  o Biopsy Follow-Up
  o Basal Cell Carcinoma (BCC)/Squamous Cell Carcinoma (SCC): Biopsy Reporting Time
<table>
<thead>
<tr>
<th>Measure</th>
<th>Submission Mechanisms</th>
<th>Max Points</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Claims</td>
<td>Qualified Registry</td>
</tr>
<tr>
<td>QPP 249: Barrett’s Esophagus Reporting</td>
<td>X</td>
<td>X</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>QPP 250: Radical Prostatectomy Reporting</td>
<td>X</td>
<td>X</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>QPP 395: Lung Cancer (biopsy/cytology)*</td>
<td>X</td>
<td>X</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>QPP 396: Lung Cancer (resection)*</td>
<td>X</td>
<td>X</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>QPP 397: Melanoma Reporting*</td>
<td>X</td>
<td>X</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>QPP 265: Biopsy Follow-Up*</td>
<td>--</td>
<td>X</td>
<td>--</td>
<td>7</td>
</tr>
<tr>
<td>QPP 440: BCC/SCC Reporting*</td>
<td>--</td>
<td>X</td>
<td>--</td>
<td>10</td>
</tr>
</tbody>
</table>

*High Priority Measures
Pathologists Quality Registry: QCDR Measures + IAs

• 21 pathology-specific measures exclusively available in the Pathologists Quality Registry
  o In addition to the 7 QPP measures
  o Total 28 measures available

• Attest to Improvement Activities

• Enhance practice success and levels of patient care via registry dashboards and quarterly benchmarking reports providing feedback on individual and/or pathology practice performance
Medicare Part B Claims Submission Continues to be Phased Out

• The CMS is limiting claims submission to small practices only (15 or fewer clinicians)
  - Individuals or groups in small practices can use claims-based reporting
  - Individuals in groups larger than 16 pathologists will no longer be able to report via claims
    - Find another reporting method, such as the Pathologists Quality Registry

• The CMS finalized multiple reporting options to help clinicians maximize their score
  - Clinicians will be able to submit a single quality measure via multiple mechanisms
  - Clinicians who are part of a group or are facility-based will also be able to report as individuals to try to maximize their score
New Facility-Based Scoring Option

• Quality and cost category scores would be assigned based on attributed facility’s Hospital Value-Based Purchasing program

• 75% or more of covered professional services
  - Inpatient hospital (POS 21) or
  - On-campus outpatient hospital (POS 22) or
  - Emergency Room (POS 23), and

• At least one service billed with POS 21 or 23

• *Facility-based pathology groups must still attest to Improvement Activities separately from the facility*

• Facility-based pathologists can also report separately/individually and *the CMS will use the highest score*
To Confirm Your 2019 MIPS Status

https://qpp.cms.gov/participation-lookup

Before you log on, have available:

1. HCQIS Access Roles and Profile System (HARP) credentials (formerly known as Enterprise Identity Data Management or EIDM)
2. Tax Identification Number (TIN)
3. National Provider Identifier (NPI)

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<thead>
<tr>
<th>SPECIAL STATUS</th>
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<tbody>
<tr>
<td>Hospital-based</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-patient facing</td>
<td>Yes</td>
</tr>
<tr>
<td>Small practice</td>
<td>Yes</td>
</tr>
<tr>
<td>Facility-based</td>
<td>Yes - UPMC HAMOT HOSPITAL</td>
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The CAP Has MIPS Resources

• Visit cap.org/advocacy for MIPS tools and resources

• 2019 Updates Coming Soon
  o Making Sense of CMS’s Quality Payment Program (Video)
  o MIPS Checklist for Pathologists
  o MIPS FAQs
  o MIPS Financial Impact Calculator
  o Understanding Your MIPS Reporting Options
  o Pathology-specific Quality Measures
  o 2019 Improvement Activities for Pathologists

• Read STATLINE
Questions?

Email us at MIPS@cap.org