## GENERAL

**What is MIPS?**

The **M**erit-based **I**ncentive **P**ayment **S**ystem (MIPS) is part of the Centers for Medicare & Medicaid Services (CMS) **Q**uality **P**ayment **P**rogram (QPP) and is the next evolution of three quality programs: Meaningful Use of electronic health records (EHR), the **P**hysician **Q**uality **R**eporting **S**ystem (PQRS), and the **V**alue-based Payment **M**odifier (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 final 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 is a federal law that stands for the **M**edicare **A**ccess and **C**HIP **R**eauthorization **A**ct 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 MACRA repealed the broken Medicare sustainable growth rate formula and reformed Medicare's reimbursement system with two new payment pathways for physicians: the MIPS and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.

## MIPS ELIGIBILITY

**How do I find out if I have to report for MIPS in 2019?**

In order to find out if you are eligible to report for MIPS, you must visit the CMS participation look-up tool at https://qpp.cms.gov/participation-lookup.

Pathologists and other clinicians who bill Medicare Part B must participate and will be subject to a penalty unless they qualify for one of the following exemptions:

1. Clinicians not meeting the Low Volume Threshold. This is defined as clinicians billing less than or equal to $90,000 in allowed charges, seeing less than or equal to 200 Medicare patients, or providing fewer than 200 covered professional services under the Physician Fee Schedule.
2. Clinicians participating as a Qualified Participant (QP) in Advanced Alternative Payment Models (APMs) are exempted from reporting MIPS.
3. Clinicians in their first year of Medicare Part B participation.

Your MIPS eligibility can change from one year to the next, so it's important that you check your eligibility for 2019. Your MIPS eligibility can also change during the performance year as the CMS looks at your Medicare claims from two 12-month segments, referred to as the MIPS determination period, to assess the volume of care you provide to Medicare beneficiaries:

- October 1, 2017 – September 30, 2018

- October 1, 2018 – September 30, 2019

You must participate in MIPS if, in **both 12-month segments**, you exceed the Low Volume Threshold as described above.

**What information do I need to find my MIPS eligibility?**

Before you log on to the CMS MIPS Participation Look Up Tool, have available:

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

The CMS determines your MIPS eligibility based on your Medicare Provider Enrollment, Chain, and Ownership System (PECOS) data and your Medicare Part B claims so it's important to ensure that the CMS has the correct PECOS information for you.

To check your **group's** 2019 MIPS eligibility:

- Log into the CMS Quality Payment Program website with your HCQIS Access Roles and Profile System (HARP) credentials (formerly known as Enterprise Identity Data Management (EIDM))
- Once logged in, browse to the Tax Identification Number (TIN) affiliated with your group
- Access the details screen to view the eligibility status of every clinician based on his or her National Provider Identifier (NPI)
- Confirm the CMS has the correct NPIs included in your TIN
- See which NPIs in the TIN are considered MIPS-eligible (for example, some may not be eligible as individuals due to falling below the low volume threshold)

To check **individual** 2019 MIPS eligibility:

- Enter your NPI into the CMS MIPS Participation Look Up Tool to see if you are MIPS eligible as an individual or a group
- Don't know your NPI number? Use the NPI Registry Public Search to find it

**What if I am not eligible to report for MIPS but I want to Opt-In?**

Starting in 2019, clinicians or groups are able to **opt-in** to MIPS if they meet or exceed one or two, but not all, of the low-volume threshold criterion. If you decide to opt-in, you will receive a final MIPS score and will receive a payment adjustment based on the data you submit. Once you decide to opt-in, you cannot reverse your decision.

You can also decide to **voluntarily** report for MIPS. If you do voluntary reporting, you will not receive a payment adjustment. However, the CMS will provide you with a performance feedback report including what your MIPS score would have been based on the data you submit.

The CMS will have more information available on how to opt-in or to voluntarily report for MIPS later in 2019.

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

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.

## SPECIAL STATUS ELIGIBILITY

**Am I a non-patient facing pathologist or group? How does that affect my MIPS reporting?**

Most pathologists are classified as non-patient facing. To confirm, pathologists and their groups should check their special status on the MIPS Participation Status website.

The CMS defines non-patient facing as:

- An individual clinician who bills 100 or fewer patient facing encounters per calendar year
- A group that has greater than 75% of its clinicians who bill 100 or fewer patient-facing encounters

If the CMS classifies you as a non-patient facing pathologist, you are only required to report on quality measures and attest to Improvement Activities; CMS will automatically reweight the Promoting Interoperability performance category. Non-patient facing groups do not qualify for automatic reweighting in the Promoting Interoperability performance category unless 100% of the MIPS eligible clinicians qualify for reweighting individually.

**What if I am in a small practice?**

If you are in a small practice defined as 15 or fewer clinicians, the CMS will indicate this on the MIPS Participation Status site. In order to reduce burden on small practices in 2019, the CMS will:

1. Assess MIPS eligibility on an additional third Low Volume Threshold criterion. Clinicians and groups are now excluded from MIPS reporting if they:
    a. Bill $90,000 or less in Medicare Part B allowed charges for covered professional services payable under the Physician Fee Schedule (PFS), or
    b. Provide covered professional services for 200 or fewer Part B-enrolled individuals, or
    c. Provide 200 or fewer covered professional services to Part B-enrolled individuals
2. Allow clinicians in small practices to report quality measures via Medicare Part B claims whether they are reporting as individuals or groups. Clinicians in practices of >16 can no longer use Medicare Part B claims to report quality measures.
3. Automatically add 6 bonus points to your quality category score if you submit at least one quality measure
4. Award you 3 points on a quality measure even if the measure does not meet data completeness requirements of 60%

**Am I a facility-based clinician or group? How does that affect my MIPS reporting?**

The CMS defines facility-based MIPS eligible clinicians as those who furnish 75% or more of their covered professional services in sites identified with Place of Service Codes 21 (Inpatient Hospital), 22 (On campus outpatient hospital), or 23 (Emergency room). In addition, clinicians must have at least one service billed with POS 21 or 23 (inpatient or Emergency Room). The CMS will determine facility-based status on an annual basis. Clinicians and their practices should check their facility-based status on the MIPS Participation Status website. A facility-based clinician is attributed to the hospital at which he or she provides services to the most Medicare patients, which will also be indicated on the MIPS Participation Status website.

MIPS eligible clinicians and groups who are eligible for facility-based measurement scoring will automatically have their MIPS quality and cost category scores assigned based on their attributed facility's Hospital Value-Based Purchasing (VBP) program.

While there are no submission requirements for individual clinicians in facility-based measurement, a pathology group must submit data in the Improvement Activities category in

order to be measured as a group under facility-based measurement. Individual clinicians who are facility-based should also attest to Improvement Activities separately in order to maximize their MIPS score. Facility-based pathologists and groups can also report MIPS data separately, and the CMS will use the highest score towards their MIPS final score.

CMS is providing a facility-based preview that allows you to see what your Quality and Cost performance category scores *could* look like for the 2019 MIPS performance period if you are identified as facility-based and attributed to a facility with a Fiscal Year (FY) 2020 Hospital VBP score. Please note that these are not your 2019 MIPS performance period Quality and Cost performance category scores under the facility-based scoring option. This preview is based on earlier data from the Hospital VBP and should give you an idea of what your facility-based scores for these performance categories may resemble. For pathologists eligible for facility-based measurement, the preview period will enable you to determine if additional Quality data submission is necessary. You can preview your facility score by signing into the QPP website and clicking Preview Facility Score from the Home page (or click the Facility Based Preview link in the left-hand navigation). If you do not have a QPP account, review the QPP Access User Guide to create one.

To learn more about facility-based measurement for MIPS in 2019, view the CMS' 2019 Facility-based Measurement Fact Sheet and the Facility-based Preview FAQs.

## INDIVIDUAL VS. GROUP REPORTING

**Can I report as an individual AND via group reporting?**

Yes, you can submit MIPS data as an individual or a group. If you are a facility-based clinician or group, you can also submit MIPS data separately. The CMS will assign you the higher MIPS score.

**Can I submit a quality measure via multiple collection types*?**

Yes, individual clinicians and groups can submit measures via multiple collection types* (eg MIPS CQM, which were previously called Registry measures, QCDR measures, and for small practices, Medicare Part B claims measures). If the same measure is submitted via multiple collection types, the CMS will select the one with the greatest number of measure achievement points for scoring.

**Note that the terminology for the mechanisms used to share data with the CMS has been updated to more accurately reflect how clinicians and vendors interact with MIPS. Instead of submission mechanisms, collection type will be used to refer to a set of quality measures with comparable specifications and data completeness criteria including, as applicable: MIPS Clinical Quality Measures (CQMs); QCDR measures, and Medicare Part B claims measures.*

**Can I submit for quality measures as an individual and attest to Improvement Activities as a group?**

No, you must report as an individual for all MIPS categories or as a group. For example, if you are reporting Medicare Part B claims for 2019 individually, you will need to attest to Improvement Activities as an individual. However, if you are a small practice choosing to group report quality measures via Medicare Part B claims, you can attest to Improvement Activities as a group.

If you send MIPS data in as an individual, your payment adjustment will be based on your individual performance. If you send your MIPS data with a group, the group will get one payment adjustment based on the group's performance. If you choose to report both as an individual and through your group, the CMS will assign you the higher MIPS final score.

**If a practice has 10 pathologists and only four 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 four 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 four 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. 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.

**Are there any benefits to group reporting?**

There might be some benefits to group reporting. Group reporting helps increase the number of cases, therefore, more pathologists could be included—making more measures available to choose from. However, if you are reporting as a group, you must include all clinicians that fall under the TIN, not just those who are eligible for MIPS. Group versus individual reporting applies to both Quality Measures and Improvement Activities (you cannot report as an individual for one and a group for the other)

**What if my National Provider Identifier (NPI) is associated with multiple Tax Identification Numbers (TINs)? Do I need to report for all TINs?**

The MIPS Participation Status look up tool will indicate which TINs your NPI is associated with. If you are associated with multiple TINs, ensure that you or your TIN is reporting for all that are MIPS eligible, otherwise you are at risk for penalties. Therefore, if you billed Medicare Part B charges under more than one group (TIN) during the performance period, you are required to participate in MIPS for each TIN association.

## REPORTING OPTIONS AND DATA SUBMISSION

**How do I submit data to comply with 2019 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. If you are a small practice, send in quality data as an individual or group through your routine Medicare claims process*. You cannot attest to Improvement Activities via claims.
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: If you are in a large practice of 16 or more clinicians, you can no longer use Medicare Part B claims to report on quality measures; you must submit using a qualified registry (QR) or qualified clinical data registry (QCDR). The **Pathologists Quality Registry** provides both options.*

**What are 2019 MIPS reporting requirements?**

Non-patient facing pathologists need to report on quality measures and attest to Improvement Activities in 2019 in order to avoid penalties in 2021.

Reporting for quality measures requires reporting on at least 6 measures for an entire year, with one being an outcome or high priority measure with 60% data completeness and 20 case minimum per measure. Review the 28 pathology quality measures available to you. Seven are MIPS Clinical Quality Measures (CQMs). The remaining 21 are pathology specific measures developed by the CAP and exclusively available in the **Pathologists Quality Registry**.

You must also attest to one high-weighted or two-medium weighted Improvement Activities to receive full credit for this category. Additionally, you must have performed the activity for at least 90 days.

For non-patient facing individual pathologists, the Promoting Interoperability (formerly Advancing Care Information) category will continue to not count and instead be reweighted to the Quality category. Non-patient facing groups do not qualify for automatic reweighting in the Promoting Interoperability performance category unless 100% of the MIPS eligible clinicians qualify for reweighting individually.

Pathologists should not be attributed to the Cost category and for most pathologists the Cost category will be reweighted to the Quality category. However, if applicable the CMS will automatically calculate scores in the MIPS Cost component using claims data from the performance period. No reporting is required of clinicians or groups. In 2019, clinicians will be scored on two cost measures, Total Per Capita Cost and Medicare Spending Per Beneficiary, and up to eight additional episode-based cost measures, as applicable. The key to the cost category is whether you are the physician responsible for the outcomes for that patient in that episode of care, and to date, the CMS methodology should not attribute the cost category to pathologists.

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

The 2019 MIPS performance period started on January 1, 2019 and closes December 31, 2019. To potentially earn an incentive under MIPS, the CMS must receive 2019 performance data before March 31, 2020, 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 2019 performance data submitted by January 31, 2020 to process the information.

The payment adjustments based on 2019 performance go into effect on January 1, 2021.

## PAYMENT ADJUSTMENTS and PERFORMANCE FEEDBACK

**How do I avoid a MIPS Penalty in 2021?**

In order to avoid penalties in 2021, practices must submit data for 2019 **no later than March 31, 2020** and score above the performance threshold of 30 points.

**How can I earn an incentive in 2021?**

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 attesting to two medium or one high Improvement Activity.

For Medicare Part B claims quality reporting, only Medicare patient data is accepted. For all other collection types the requirement is to report on 60% of all patients for which the measure applies.

If you earn between 30.01 and 74.99 points you will receive a payment increase on a linear scale up to 7% on your Medicare Part B payments in 2021. Due to budget neutrality of the program, the negative payment adjustments have to equal the positive payment adjustments. Therefore, you could see your payment adjustment vary anywhere in the range of -7% to +7% based on how many clinicians participate in MIPS and qualify for positive payment adjustments. In order to achieve an exceptional payment bonus from a separate pool of $500 million, a clinician or practice must earn more than 75 MIPS total points for the year.

**What if I move practices during the performance year?**

The MIPS score follows the NPI in all cases; therefore a clinician will receive reimbursement in 2021 based on 2019 performance regardless of their TIN in 2021.

In the case if you start working in a new practice or otherwise establish a new TIN that did not exist during the performance period, there would be no corresponding historical performance information or final score for your new TIN/NPI. If there is not a final score associated with a TIN/NPI from the performance period, the CMS will use the NPI's performance for the TIN(s) the NPI was billing under during the performance period.

If you worked in one practice (TIN A) in the performance period of 2019 but are working at a new practice (TIN B) during the payment year of 2021, then the CMS will use the final score for the old practice (TIN A/NPI) to apply the MIPS payment adjustment for the NPI in the new practice (TIN B/NPI). If you billed under more than one TIN during the performance period of 2019, and you start working in a new practice or otherwise establish a new TIN that did not exist during the performance period, the CMS will take the highest final score associated with the NPI in the performance year.

If you start billing Medicare Part B claims at a TIN between October 1, 2019 and December 31, 2019 and the practice participates as a group, you will receive the group's final score and associated payment adjustment. You will receive a neutral payment adjustment if the practice does not report as a group.

**Will I receive performance feedback?**

Yes, the CMS will provide you with performance feedback based on the data you submit for 2019 starting in July 2020. You should review this performance feedback as it will inform your MIPS submission for subsequent years. If you find that the CMS' performance feedback in incorrect, you should submit a targeted review request. The CMS will open the window for targeted review after it provides you with performance feedback. Look for additional communications from the CAP once performance feedback is available and the targeted review window is open.