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MIPS: Closing-out 2018 and Reviewing the Changes for Performance Year 2019 That Pathologists Need to Know

APS recently signed-off on the 2018 MIPS data that will be submitted on behalf of our clients to CMS in time for the April 2, 2019 deadline as required by the Quality Payment Program (QPP). In order to closely monitor progress and work with our clients to ensure that optimal performance is being achieved, APS directly contracts with a qualified data registry to maintain the required data for each category of MIPS, as well as performing a continuous cycle of analysis of the data being submitted under the quality category throughout the performance year.

This means that APS is actively working on our clients' MIPS data year-round in preparation for the annual deadline to CMS. We create an ongoing cycle of uploading our client's quality data to the registry for analysis. The return results are individually reviewed by APS staff to monitor progress, confirm coding accuracy, and identify any needed follow-up with clinicians for additional documentation. This allows us to make appropriate updates in near-real time; the cumulative data is then re-uploaded for processing and the cycle begins again. To provide a sense of the volume created by this process, over 100 million cumulative patient accounts were analysed on behalf of our clients in the 2018 performance year.

2019, year 3 of the MIPS program, brings some changes. Some of those changes reflect CMS' efforts to reduce physician burden associated with the data collection and reporting required of MIPS. On the other hand, some of the requirements have been made more challenging. In fact with the increased rules this year, CMS is predicting a median score of 78.72 in 2019 which is 11.5% lower than the median score of 88.97 in performance year 2017.

First, let's take a look at the main rules that apply for 2019.

➢ Low Volume Threshold for Participation Has Been Updated

To avoid the regulatory burden of participation for physicians/groups who have a low volume of Medicare services, CMS now has 3 criteria identifying low volume threshold. **To be excluded from MIPS, clinicians or groups need to meet 1 or more of the following:**

2019 Low Volume Threshold
Have ≤ $90K in Part B Allowed Charges for covered professional services;
Provide care to ≤ 200 Part B-enrolled beneficiaries;
Provide ≤200 covered professional services under the Physician Fee Schedule

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New this year, clinicians or groups that meet 1 or 2 of the Low Volume criteria (but not all 3) can opt-into MIPS 2019. Clinicians/Groups that opt-in will be subject to the same program requirements and will receive a negative, neutral, or positive payment adjustment based on their final MIPS scores.

➢ PAYMENT ADJUSTMENT MAXIMUM INCREASES TO 7%

Performance Year	Maximum Payment Adjustment
2019	-7% - +7%
2018	-5% - +5%
2017	-4% - +4%

Under MACRA, MIPS is required to be budget-neutral. As such, the exact amount of the adjustment can vary, driven by the number of participants who end up in the bonus and penalty pools. Earlier this year CMS predicted it would distribute incentives to the tune of nearly $400 million in 2019. This doesn't include the funds ear-marked for the Exceptional Performance Bonus, described below.

➢ PERFORMANCE THRESHOLD DOUBLES

Performance Year	Performance Threshold
2019	30 points
2018	15 points
2017	3 points

This means that for 2019 participants will have to score a minimum of 30 points in the MIPS program to avoid the payment penalty. Still doable for most groups, but keep in mind that the performance threshold is projected to continue increasing by 15 points each year until 2022.

➢ EXCEPTIONAL PERFORMANCE THRESHOLD INCREASES BY 5 POINTS

Many clinicians are unaware of the Exceptional Performance Bonus as it wasn't reflected as a separate bonus in the 2017 MIPS Feedback Reports to participants which made it difficult to identify. In short, there is a pool of $500 million slated for this particular bonus. To be eligible for a share of this pot, MIPS participants will need to score a minimum of 75 MIPS points in 2019.

➢ SMALL PRACTICE INCENTIVES ARE STILL IN THE MIX

Small Practices are defined as those with 15 or fewer clinicians. In 2019, these groups will receive the Small Practice bonus of 6 points, up from 5 points last year, as long as the physician/group submits data on a least 1 quality measure. Small Practices will also continue to receive 3 points for quality measures that do not meet the data completeness requirements.

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➢ New Facility-Based Scoring Option

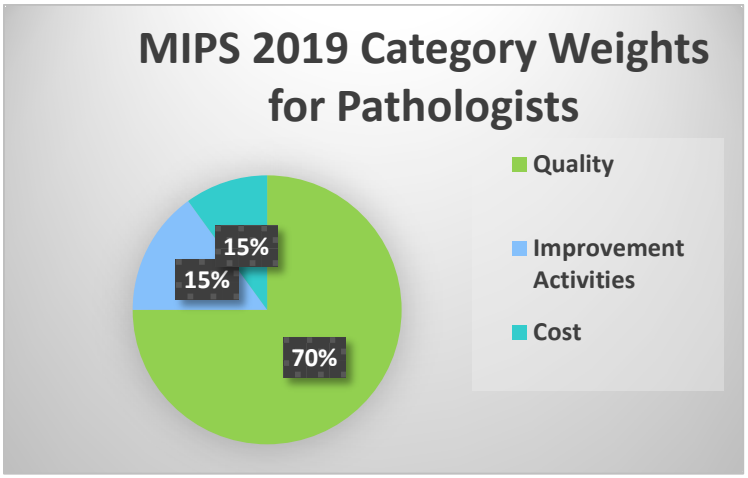
This year, CMS has added an option to use facility-based measurement for the Quality and Cost performance categories for eligible clinicians/groups designated as facility-based. These clinicians would have to be able to be attributed to a facility with a Fiscal Year 2020 Hospital Value-based Purchasing (VBP) score. If so, they could be assessed based on their performance in hospital settings.

Look for more information in the coming weeks as additional details become available and this option is further clarified.

Now, let's review the changes and requirements to the categories for this year.

Same as 2018, clinicians/groups identified by CMS as Non-Patient Facing and/or Hospital Based are exempt from the Promoting Interoperability category so its weight is reallocated to the Quality category. Remember, this is the category related to the use of EHRs and prior to the inception of the MIPS program was referred to as Meaningful Use.

This means that the vast majority of **pathologists will be scored on the 3 remaining MIPS categories of Quality, Practice Improvement Activities and Cost.** Their respective weights to the final score are reflected below.



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QUALITY CATEGORY: CHANGES THAT PATHOLOGISTS NEED TO KNOW

The following 3 measures have been deleted for 2019 because they were 'Topped-Out.' This means their average scores have been consistently high with a distinct lack of variability. When a measure is designated as Topped-Out it follows the CMS process to eventually be deleted from the program.

Measure ID	Measure Description	Status for 2019
99	Breast Cancer Resection	**DELETED**
100	Colorectal Cancer Resection	**DELETED**
251	IHC Evaluation of HER2 for Breast Cancer Patients	**DELETED**

The remaining measures for pathology are the same as previous years and are listed below. Again this year, clinicians/groups will report on 6 measures, one of which must be designated an Outcome or High Priority measure.

Measure ID	Measure Description	Outcome/High Priority Measure
249	Barrett's Esophagus	No
250	Radical Prostatectomy	No
395	Lung Cancer – Biopsy/Cytology Specimens	High Priority
396	Lung Cancer – Resection Specimens	High Priority
397	Melanoma Reporting	High Priority
440	Basal Cell Carcinoma/Squamous Cell Carcinoma Biopsy Reporting Time	High Priority

Information provided by APS Medical Billing, March 2019

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PRACTICE IMPROVEMENT ACTIVITIES CATEGORY: NO BIG CHANGES FOR 2019

Each activity is weighted as either high or medium. High-weighted activities receive 20 points and medium, 10 points. To earn full credit in this category, physicians/groups will attest to the activities that apply to his/her/their practice and have been performed for at least 90 consecutive days during the performance year.

There is a 40-point maximum score for this category. Again this year, physicians/groups will receive double points for each activity if they have been designated by CMS with any of these special statuses:

- Small Practice
- Non-Patient Facing
- Rural
- Health Professional Shortage Area (HPSA)

Small Practice, Non-Patient Facing and/or Clinicians Located in a Rural Area or HPSA	**Group with More than 15 Clinicians that aren't in a Rural Area or HPSA**
*report 1 high-weighted activity OR *2 medium-weighted activities	*report 2 high-weighted activities OR *1 high-weighted activity and 2 medium-weighted activities OR *4 medium-weighted activities

Look for more information in the upcoming weeks on this category as we confirm individual activity specs and documentation requirements for 2019.

COST CATEGORY: INCHES UP TO 15% OF THE TOTAL SCORE THIS YEAR

This category looks at 2 measures: Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB). As promised, CMS is easing this category into the MIPS program rather slowly. Performance Year 2018 was the first year the category contributed to the scoring (10%) and many participants are anxious to see their 2018 results to get a better understanding of how this category is actually measured and calculated.

Because this data is captured from adjudicated claims analysis, no additional data submission is required for this category.

Now, let's get started for 2019.

To check your 2019 MIPS status:

- Exempt or expected to participate
- Noted as being an Advanced Payment Model (APM) participant
- Designated as Small Practice, Non-Patient Facing, Rural, HPSA, of Facility-Based

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Simply visit the link to the Quality Payment Program:

https://qpp.cms.gov/

Select **Check Participation Status**
Enter your NPI
Select the **PY 2019** tab

Note:

- If you bill Medicare under more than 1 TIN, be sure to review the eligibility information for each practice listed
- If you are listed as an APM participant, you will need to check with your APM entity for instructions for this performance year. In that event, please notify your APS Practice Manager of this information as well.

APS will continue to keep our clients apprised of current MIPS information as it becomes available. In the meantime, please direct questions to your APS Practice Manager or MIPSInfo@apsmedbill.com.