COSMOS
Navigate the Compliance Universe

Compliance Today - April 2019
Medicare Incentive Payment System: An update for MIPS in 2019

By Cybil G. Roehrenbeck, Mary Tobin, and Neal Shah

Cybil G. Roehrenbeck, JD (croehrenbeck@polsinelli.com) is a Shareholder in the Washington, DC offices of Polsinelli, PC. **Mary B. Tobin, JD** (mtobin@polsinelli.com) and **Neal Shah, JD, MPH** (nshah@polsinelli.com) are Associates in the Chicago offices of Polsinelli.

On April 14, 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law.[1] MACRA provided a permanent repeal of the Sustainable Growth Rate (SGR), which had previously prompted an annual recalculation, an often mandated decrease requiring Congressional intervention in physician and other clinician payment under Medicare Part B.[2]

The 2015 law also included a new value-based system for determining Medicare Part B payment, namely, bonuses for increased quality and decreased cost, as well as penalties for failure to accomplish the same. Beginning in 2017, certain eligible Medicare practitioners participated in one of two MACRA tracks: as a participant in an Advanced Alternative Payment Model (AAPM) designated by the Centers for Medicare & Medicaid Services (CMS); or, in the Medicare Incentive Payment System (MIPS), which requires reporting on a number of quality and cost measures, as well as compliance with certain information security and other requirements.[3]

Clinicians or groups who qualify as MIPS-eligible are required to participate in the program in 2019 or may face a 7% penalty on 2021 Medicare reimbursement.[4] 2019 will be the third year that eligible clinicians participate in MIPS and, unlike 2017 and 2018, this year is not considered to be a "transition" year by CMS. CMS made changes to the rules governing the 2019 MIPS participation year in the Medicare Physician Fee Schedule Rule for 2019 (final rule), published November 1, 2018. The rule makes some significant modifications to the MIPS program, including changes to the criteria to qualify as a "MIPS-eligible" clinician and updates to the four key MIPS performance categories of Quality, Cost, Advancing Care Information (ACI) requirements for electronic health records (EHRs), and Improvement Activities.

This article reviews areas where you or your administrative staff may need to update your compliance protocol to ensure complete and successful MIPS participation in 2019.

MIPS low-volume threshold

Eligible clinicians are not required to report under MIPS, and will not have their payments adjusted, if they fall under the low-volume threshold.[5] CMS has added a third criterion for determining MIPS eligibility under the low-volume threshold.[6] Previously, to be excluded from MIPS, clinicians and groups needed to either have less than $90,000 in Part B allowed charges for covered professional services or provide care to fewer than 200 Part B-enrolled beneficiaries.[7] The final rule added an additional criterion, namely that clinicians and groups who provide fewer than 200 covered professional services under the Medicare Physician Fee Schedule may be excluded from MIPS.[8]

CMS indicated that setting a threshold of 200 services for the third criterion, combined with its policy for opting in to MIPS (discussed below), "strikes the appropriate balance between allowing a significant number of eligible clinicians the ability to opt-in to MIPS and consistency with the previously established low-volume threshold criteria." The additional criterion provides clinicians and groups additional flexibility to decide whether to participate in the program. Clinicians or groups who are unsure if they are eligible to participate in MIPS or exempt should log in to the CMS Quality Payment Program (QPP) Participation Status tool (https://qpp.cms.gov/participation-lookup) to confirm.

The final rule also finalized opt-in provisions starting in 2019 for clinicians and groups seeking to participate in MIPS but who are otherwise excluded based on the low-volume thresholds. Individual clinicians or groups can opt-in to MIPS if they meet or exceed at least one, but not all three of the low-volume threshold criteria, listed above.

Prior to this change, eligible clinicians who fell under any of the low-volume thresholds could not opt-in to the program. The change presents an opportunity for increased participation for a wider range of providers, although once an eligible clinician has decided to opt-in to the program, the decision is irrevocable and cannot be changed for the performance period. Eligible clinicians and groups need only to log into their account on the Quality Payment Program Portal and select the option to opt-in. The deadline for eligible clinicians who fell under one of the low-volume threshold options to opt-in to MIPS for 2019 was December 31, 2018, although CMS indicates that it is exploring more flexible deadlines for eligible clinicians wishing to opt-in to the program.[9]

New criteria for data submission and claims-based measures.

CMS refined its description of data submission in the final rule. Rather than the old categories of qualified registries, Qualified Clinical Data Registries (QCDRs), electronic health records (EHRs), claims-based reporting, and administrative claims, CMS now refers to "data submission types."[10] The new terms, which focus on the way an eligible clinician, group, or third party intermediary transmits data it has collected to CMS, are "Direct," "Log in and attest," "CMS Web Interface," and "Medicare Part B Claims." Although CMS will still use the same technologies to collect and submit data, eligible clinicians should understand the new terminology that will be used by CMS.

As part of its changes, CMS modified the types of individuals and entities who are permitted to report MIPS quality performance data using claims-based measures. Claims-based reporting consists of reporting quality measures by including certain codes on the eligible clinician's claims for payment. Previously, this option was available only for eligible clinicians who reported as individuals.[11] In the final rule, CMS changes this criteria. Under the new rule, claims-based reporting for quality performance data is available only to groups of less than 15 eligible clinicians or individual clinicians in those groups.[12] Individual clinicians in larger groups will not be permitted to report quality performance data using claims-based measures.

Larger groups (and individual clinicians in larger groups) may continue to report data on the quality category using other options, including a QDCR, qualified registry, EHR, and the CMS Web Interface.

Reporting quality data using multiple collection types

Under the final rule, CMS creates a new category of "collection types" to describe the actual data collected by the various data collection mechanisms.[13] A collection type is a set of quality measures with comparable specifications and data completeness criteria. These include:

- MIPS Clinical Quality Measures (mCQMs): CMS-defined quality measures collected by either QCDRs or

qualified registries,

- QCDR measures: non-CMS measures that can only be collected by QCDRs,
- electronic clinical quality measures (eCQMs): quality data collected by EHRs,
- CMS Web Interface measures: data that can only be provided through the Web Interface,
- the CMS approved survey vendor measures: data that can only be provided through CAHPS, and
- certain applicable administrative claims measures.

Eligible clinicians participating as individuals as well as groups of eligible clinicians can report quality performance data using multiple collection types under the final rule. Previously, eligible clinicians could collect data using multiple methods, but CMS would only use the data reported from one method for each MIPS category.[14] Under the final rule, CMS allows both individuals and groups to collect and report data using multiple methodologies, even for the same category.[15] For example, if a group reports a quality measure that is a mCQM (through a qualified registry) as well as the same quality measure as an eCQM (through an EHR), CMS will select the one with the greatest number of measure achievement points for scoring.

New specifications for CMS Web Interface measures

As discussed above, the final rule allows groups to submit measures in the quality performance category using multiple collection types, including mCQMs, eCQMs, and QCDR measures. The rule, however, limits the submission of CMS Web Interface measures, which cannot be scored with other collection types, apart from the CMS approved survey vendor for CAHPS for MIPS and/or administrative claims measures, and thus, groups wishing to submit CMS Web Interface measures are limited to these data collection methods.[16]

As was previously the case, the submission of CMS Web Interface measures is only available for groups of 25 or more eligible clinicians who can report 12 months of quality measure data.[17] Under the new rule, groups must ensure that they submit data using only the collection types applicable to both the size of their practice, as was true prior to the 2019 rule, as well as the use of the CMS Web Interface.

In the final rule, CMS also discontinued high-priority measure bonus points for CMS Web Interface reporters. In past years as well as in Year 3, CMS awards bonus points for reporting high-priority measures.[18] Eligible clinicians can receive two bonus points for outcome or patient experience measures and one bonus point for other high-priority measures (e.g., appropriate use, patient safety, care coordination, opioid-related quality measures) that meet certain additional criteria.[19] Under the new rule, CMS will no longer award bonus points for high-priority measures reported through the CMS Web Interface.

Clinician performance guidelines under the cost component of MIPS.

CMS also finalized changes to the evaluation of clinician performance under the MIPS cost performance category. CMS increased the weight of cost performance to the final score from 10% to 15% and added eight new episode-based measures to the cost performance category.[20] Now, CMS may use up to 10 measures to assess Medicare Part A and B charges associated with patient care. All clinicians and groups will be evaluated on the same cost measures if they meet or exceed the measures' minimum case volume necessary for the specific measure to be evaluated. The measures continue to be assessed by claims data, meaning that clinicians and groups do not have to separately submit data for this performance category.

Previously, clinicians were evaluated only on the basis of the Total Per-Capita Cost and Medicare Spending Per Beneficiary measures, which evaluate the cost of all Medicare-covered services provided to patients by certain providers over a given timeframe.[21] Under the new rule, clinicians will be evaluated on a variety of measures based on a specific set of clinical services, including:

- elective outpatient percutaneous coronary intervention (PCI)
- knee arthroplasty
- revascularization for lower extremity chronic critical limb ischemia
- routine cataract removal with intraocular lens (IOL) implantation
- screening/surveillance colonoscopy
- intracranial hemorrhage or cerebral infarction
- simple pneumonia with hospitalization
- ST-Elevation myocardial infarction (STEMI) with PCI[22]

For each new measure, CMS will calculate a score if a minimum of 10 cases for procedural episodes and 20 cases for acute inpatient medical condition episodes are attributed to the clinician or group. The addition of episode-based measures allows CMS to better evaluate care related to a specific event and more accurately measure value associated with an episode of care.

Conclusion

The 2019 changes to MIPS provide eligible clinicians with increased flexibility, particularly those participating in small groups or meeting low volume thresholds. CMS also reduces burden on eligible providers by allowing reporting of measures through multiple collection types. The Final Rule is not without its limitations, though, as some eligible providers will be more restricted in the use claims-based measures as well as CMS Web-based Interface measures. Eligible clinicians should understand all of the changes moving forward to ensure that they understand if their participation in MIPS is required; and if it is, how they can accurately and compliantly report measures to CMS under the program.

Takeaways

- CMS added a criterion to the low-volume threshold (clinicians providing less than 200 covered professional services) and now allows certain clinicians to opt-in to the program.
- Claims-based reporting for quality performance data is now available only to groups of less than 15 eligible clinicians or individual clinicians in those groups.
- Eligible clinicians participating as individuals as well as groups of eligible clinicians can report quality performance data using multiple collection types.
- CMS made changes to the use of its Web-based Interface, including discontinuing high-priority measure bonus points for measures reported through the Web Interface.
- Clinicians meeting minimum case volumes will be evaluated on eight new episode-based measures in addition to the Total Per-Capita Cost and Medicare Spending Per Beneficiary measures.

1 The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Pub. L. 114-10, enacted April 16, 2015.
2 Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33) § 1848(f)(2)(repealed 2015).
3See MACRA § 102.
4 83 Fed. Reg. 59453, 59726 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019, November 23, 2018
5 42 C.F.R. § 414.1310(b)(iii)
6 42 C.F.R. § 414.1305
7 82 Fed. Reg. 53568, 53588 Medicare Program; CY 2018 Updates to the Quality Payment Program, November 16, 2017. (codified at 42 C.F.R. 414.1305)
8 83 Fed. Reg. at 59732 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019 (codified at 42 C.F.R. 414.1305)
9 83 Fed. Reg. at 59738 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019
10See 42 C.F.R. § 414.1305.
11 82 Fed. Reg. at 53912Medicare Program; CY 2018 Updates to the Quality Payment Program
12 42 C.F.R. § 414.1325(c)(1)
13 Idem at § 414.1305
14 82 Fed. Reg. at 53620 Medicare Program; CY 2018 Updates to the Quality Payment Program
15 Idem at § 414.1325(d).
16 Idem at § 414.1335(a)(2).
17 Idem at § 414.1325(c)(1).
18 Idem at § 414.1380(a)(1)(i).
19 Idem at § 414.1325(b)(1)(v)(A).
20 Idem at § 414.1350(d).
21 Idem at § 414.1350(c).
22 83 Fed. Reg. at 59769 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019