MACRA Collaborative
Merit-Based Incentive Payment System

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Overview

QPP Final Rule: MIPS

- MIPS Refresher
- Performance Category Reporting & Scoring
  - Quality
  - Advancing Care Information
  - Improvement Activities
  - Cost
- Final Score Calculations & Payment Adjustments

MACRA QPP Participation Categories

SUBJECT TO MIPS

MIPS Eligible Clinician

Eligible clinicians not meeting APM thresholds, or low-volume or new to Medicare exclusions

MIPS APM Participant

MIPS eligible clinicians participating in Advanced APM models—plus MSSP Track 1 & one-sided OCM—but below partial qualifying thresholds

Partial Qualifying APM Clinician

Eligible clinicians not meeting Advanced APM thresholds, but coming close

Advanced APM Qualifying Clinician

Eligible clinicians meeting full participation thresholds in Advanced APMs

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Merit-Based Incentive Payment System (“MIPS”)

Measure Performance

- Two year look-back: performance measurements begin in 2017 for 2019 adjustments
- 4 weighted categories – Quality, Cost, Advancing Care Information, Improvement Activities
- EHR MU, PQRS, and VBM – sunset in 2018, with many measures incorporated into new MIPS categories

Composite Score

- Participants receive an annual final score between 0-100
- Score will be publicly available via Physician Compare

Threshold Comparison

- Each clinician’s score compared against a Performance Threshold to determine payment adjustments
- Beginning in 2019, performance threshold will be based on the median of MIPS scores

Additional Adjustments

- Adjustments are budget neutral – upward adjustment can be scaled up or down, with the scaling factor not to exceed 3 times the baseline adjustment
- Additional exceptional performance adjustment offered to small number of best performers

MIPS Eligibility Likely to Expand Over Time

In first 2 years, eligible providers include:
Physicians (MD, DO, DDS, DMD, DPM, OD, DC), PAs, NPs, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such professionals

After year 2, HHS can determine other eligible professionals to subject to MIPS
Physical/occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dieticians/nutritional professionals

3 Exclusions to MIPS participation

1. Falls below “low-volume threshold”
2. First year of Medicare Part B participation
3. Qualification for Advanced APM Track (or Partial Qualifying)

MIPS Reporting Options

INDIVIDUAL

- Reports at individual level for each of the 4 performance categories
- Receive individual score/payment adjustment at TIN/NPI level

GROUP

- A group, defined by TIN, would be assessed as group across all 4 performance categories
- Receive score/payment adjustment at TIN/NPI level
- All MIPS clinicians in group receive the same annual score
- CMS will ultimately allow reporting through virtual groups, though not in 1st performance year

APM ENTITY

- Option available to MIPS clinicians practicing in an APM deemed a "MIPS APM"
- All scores aggregated at APM Entity level
- All individuals in APM Entity receive the same annual score

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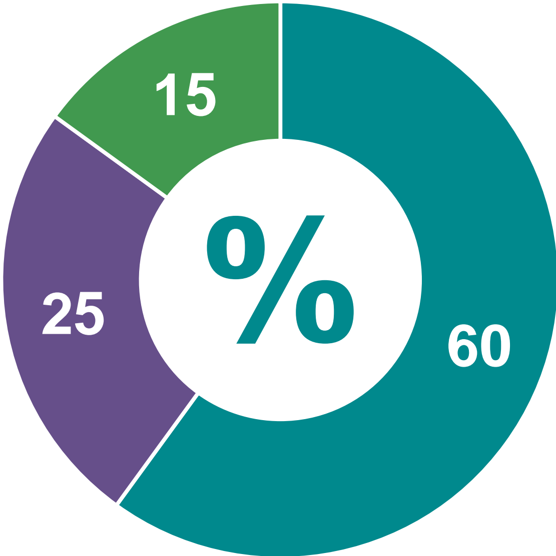
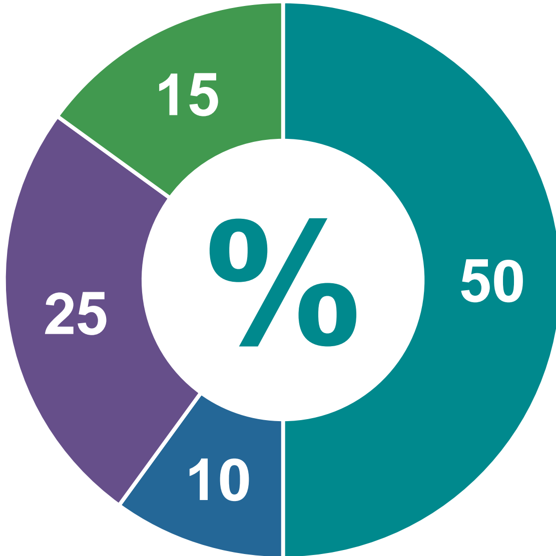
Generally Applicable MIPS Category Weighting

2017 Performance Year
2019 Payment Year



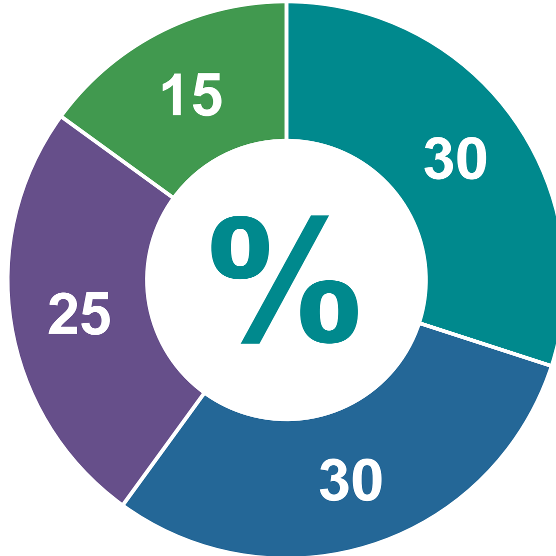
- Quality
- Advancing Care Information
- Improvement Activities

2018 Performance Year
2020 Payment Year



- Quality
- Cost
- Advancing Care Information
- Improvement Activities

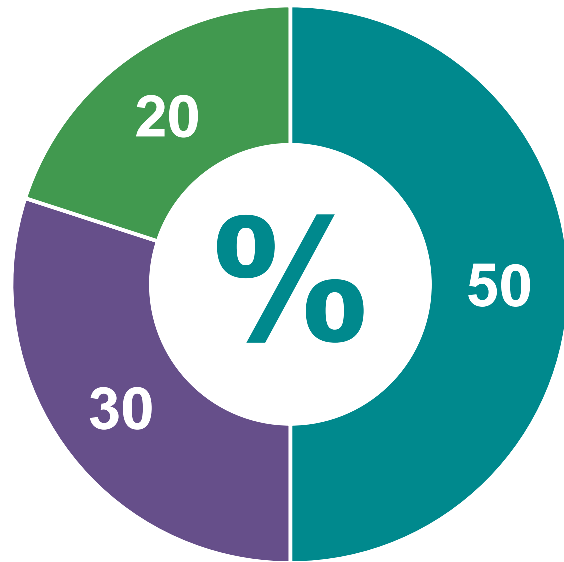
2019 Performance Year
2021 Payment Year



- Quality
- Cost
- Advancing Care Information
- Improvement Activities

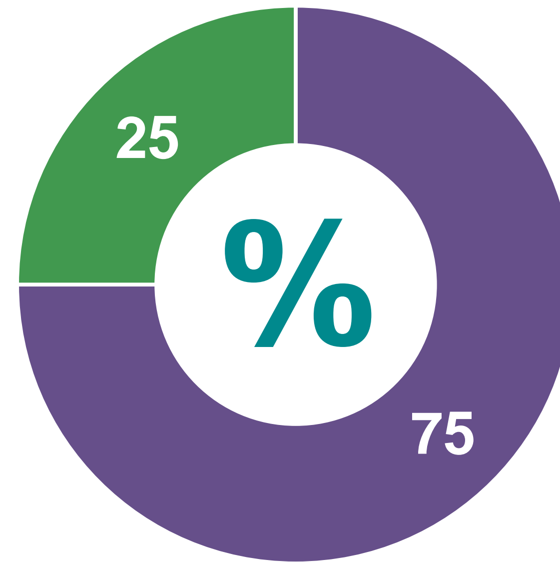
Weighting of Performance Categories for MIPS APMs

MSSP & Next Gen ACOs



- Quality
- Advancing Care Information
- Improvement Activities

Other MIPS APMs



- Advancing Care Information
- Improvement Activities

Quality: Overview

STRUCTURE LARGELY FINALIZED AS PROPOSED

- Clinicians/groups will choose 6 measures (if report more, will be scored on best 6), including 1 outcome measure
- Specialists may choose from a specialty-specific set, which may have fewer than 6 measures
- Groups using CMS Web Interface must report all 14 measures (can not pick just 6)

FEWER REQUIREMENTS

- Cross-cutting measure no longer required
- CMS will calculate only 1 population health measure (All-Cause Hospital Readmissions), if group >15
- Data completeness thresholds lessened
- 90-day minimum performance period for 2017, increasing to full year in 2018

MORE FLEXIBILITY IN SCORE

- Increasing bonus cap to 10% for additional high-priority measures in first 2 years
- Increasing bonus cap to 10% for CEHRT use in first 2 years

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Quality: Reporting

Reporting Category	Data Submission Methodology	Data Submission Mechanism
Individual	Each clinician submits individually, at TIN/NPI level	Claims, QCDR, qualified registry, EHR
Group	Each group submits at TIN level	QCDR, qualified registry, EHR, CMS Web Interface (for groups of 25 or more), CAHPS
APM Entity *(MSSP and Next Gen ACOs)*	Data submitted at ACO level	ACO submits data as usual—no additional reporting for MIPS
APM Entity *(Other MIPS APMs)*	N/A—category reweighted to zero	N/A

- **Data Completeness Thresholds:**
  - Individuals using Medicare Part B claims: Report on > 50% of Medicare Part B patients
  - Individual/group using QCDR, qualified registry, EHR: Report on > 50% of all-payer patients
  - Groups using CMS Web Interface: Report on all measures included in Interface & populate data for first 248 consecutively ranked/assigned beneficiaries *(must report 12 months of data)*
- **Case Minimum:**
  - 20 cases for all reportable Quality measures; 200 for ACR

Quality: Bonuses Incentivize Outcomes & CEHRT

Clinicians can earn up to 20% of possible total in bonus points for reporting additional measures or using CEHRT

- Up to 10% for reporting certain additional measures—2 points for additional outcome or patient experience measures, 1 point for additional other high priority measures
- Up to 10% for reporting using CEHRT—1 point for each measure reported using CEHRT for end-to-end electronic reporting

Those reporting through CMS Web Interface will get automatic bonus points for high-priority measures, and will be eligible for CEHRT bonus points

Quality: Scoring for Individuals & Groups Not Using CMS Web interface

Each reported measure assigned 1-10 points based on comparison to benchmarks (minimum 3 in 2017)

Benchmarks calculated from data 2 years prior, or from performance year

Quality Domain Score = (**Sum of all points for required scored (6-7) measures** + **Bonus points for high priority measures and CEHRT reporting (subject to cap)**) / **Total possible points**

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Quality: Scoring for Groups using CMS Web Interface & ACOs

Each reported measure assigned 1-10 points based on comparison to benchmarks (minimum 3 in 2017)

Scored against MSSP benchmarks

Groups must report all 14 measures, but in 2017 are only scored on 11 (+ ACR for non-ACO groups)

Quality Domain Score = (**Sum of all points for required scored measures** + **Bonus points for high priority measures (5 of 14 measures) & CEHRT reporting**) / **Total possible points**

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Quality: Scoring Example for Groups using CMS Web Interface

Examples	Reported 14 measures Yes/No	Number of measures Not Reported	Number of measures Not scored**	Quality Performance Category Numerator/ Denominator (Assume all measures reported received 10 points and the score for the readmission measure* is 3 points)	Quality Performance Category Score Numerator/ Denominator x (weight of quality performance category of 60) = Points Toward the Final Score
Reported 14 measures	Yes	N/A	3	11 measures x 10 points + 1 measures x 3 points/120	113/120 x 60 = 56.5
Reported 11 measures, did not report 3 measures without a benchmark	No	3 measures lacking a benchmark	0	11 measures x 10 points + 1 measures x 3 points/150	113/150 x 60 = 45.2
Reported 13 measures, did not report measure with a benchmark	No	1 measure with a benchmark	3	10 measures x 10 points + 1 measure x 3 points/120	103/120 x 60 = 51.5

Advancing Care Information: Overview

Scoring:

- Base Score: Yes/no or numerator/denominator measures that clinicians must meet
- Performance Score: Clinicians select from a set of measures that best fit their practice, around patient electronic access, patient engagement, health information exchange

Even more flexibility built in:

- 155 total possible points – need 100 for maximum score
- 50% base score; 90% for performance measures; 5% bonus for reporting to additional public health registries; 10% for use of CEHRT in certain Improvement Activities
- 90-day minimum performance year for 2017 and 2018, then increasing to full year

Advancing Care Information: Base Score

To receive the base score, clinicians must provide the numerator/denominator or “yes”/ “no” for each measure within the following objectives:

Protecting patient health information
- Security Risk Analysis

Electronic prescribing
- e-Prescribing

Patient Electronic Access
- Provide Patient Access*

Health Information Exchange
- Send a Summary of Care*
- Request/Accept a Summary of Care*

Clinicians will need to achieve the base score in order to receive a score for the category

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Advancing Care Information: Performance Score

Clinicians will select the measures that best fit their practice from the following objectives:

Patient Electronic Access

- Provide patient access*
- Patient-specific education

Coordination of Care Through Patient Engagement

- VDT
- Secure messaging
- Patient-generated health data

Health Information Exchange

- Send summary of care*
- Request/accept summary of care*
- Clinical information reconciliation

Public Health and Clinical Data Reporting

- Immunization registry reporting

Clinicians can earn bonus points for participating in additional public health registries, and for submitting certain Improvement Activities using CEHRT

Advancing Care Information: Reporting

Reporting Category	Data Submission Methodology	Data Submission Mechanism
Individual	Each clinician submits individually, at TIN/NPI level	Attestation, QCDR, qualified registry, EHR
Group	Each group submits at TIN level	Attestation, QCDR, qualified registry, EHR, CMS Web Interface (for groups of 25 or more)
APM Entity *(MSSP ACO)*	Each participating TIN submits data; scores averaged to weighted mean MIPS APM Entity level score	Attestation, QCDR, qualified registry, EHR, CMS Web Interface (for groups of 25 or more)
APM Entity *(Next Gen , all Other MIPS APMs*	Clinicians submit individual data; scores averaged at APM Entity level	Attestation, QCDR, qualified registry, EHR

- Data submission criteria same when submitted at group-level as individual-level, but aggregated for all clinicians within the group
- For APM Entity reporting (other than MSSP ACO models) each clinician in the APM Entity will be attributed one score, which will be highest of the clinician's individual or group score

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Advancing Care Information: Scoring Methodology

BASE SCORE

- Full credit for answering “yes” and submitting numerators >1 for each measure under the 5 objectives
- Clinicians/groups not meeting submission criteria for any measure in the base score will receive category score of 0
- **50 points**

PERFORMANCE SCORE

- Clinicians/groups receive 1-10 points for each of 8 measures, based on their performance rate above the base score
- Clinicians/groups receive 10 points for reporting to an immunization registry
- **90 points available**

BONUS POINTS

- Clinicians/groups may earn 5 bonus points in the category for reporting to any additional public health or clinical data registry
- Clinicians/groups can earn 10 bonus points for achieving at least one Improvement Activity through use of CEHRT
- **15 points available**

Advancing Care Information: Scoring

Advancing Care Information Domain Score = Base Score **(50 points)** + Performance Score **(90 points)** + Bonus **(15 points)**

If clinicians/groups earn ≥ 100 points, they receive maximum score

If clinicians/groups earn < 100 points, their overall score in MIPS declines proportionately

Improvement Activities: Overview

- List of 90+ activities largely finalized as proposed
- Requirements lessened—maximum possible score finalized at 40 points, a decrease from the proposed 60 points
- MIPS clinicians participating in PCMHs will be guaranteed maximum score; minimum half credit for participation in APM
  - Broad definition of PCMH
- No minimum participation thresholds as long as activity performed for at least 90 consecutive days (though may be modified in future years)

Improvement Activities: Reporting

Reporting Category	Data Submission Methodology	Data Submission Mechanism
Individual	Each clinician submits individually, at TIN/NPI level	Attestation, QCDR, qualified registry, EHR
Group	Each group submits at TIN level	Attestation, QCDR, qualified registry, EHR, CMS Web Interface (for groups of 25 or more)
APM Entity *(ALL MIPS APM entities)*	APM Entities only need to report if the CMS-assigned score is below the maximum score	The APM Entity will have the opportunity to report additional activities if necessary

- In Year 1, all clinicians/groups/3rd party entities must designate yes/no response for all activities on Inventory
- For 3rd party submission, clinicians/groups will certify all activities have been performed and health IT vendor, QCDR, or qualified registry will submit on their behalf
- All current MIPS APMs will automatically receive full credit—no reporting necessary

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Improvement Activities: Scoring

Each activity is worth a set number of points:

- Medium weight activity = 10 points
- High weight activity = 20 points

Activities that support the PCMH or the transformation of clinical practice are highly weighted activities

Improvement Activities Domain Score = (Total points for high-weight activities + Total points for medium-weight activities) / Total possible points (40)

Cost: Overview

- Domain eliminated for 2017 due to attribution & scoring differences from (clinicians/groups will still receive feedback)
- Cost measures finalized as proposed
- CMS will continue to develop new care episode, patient condition, and patient relationship codes, to be included in claims beginning on or after 1/1/2018
  - List of patient relationship codes will be posted by 4/2017 & list of codes for care episodes and patient conditions will be posted by 12/2017
  - New codes will likely not immediately factor into Cost measures in 2018—CMS will need time to evaluate

Cost: Measures

Measures include:

- Total per capita costs (Parts A and B) for all attributed beneficiaries
- Medicare spending per beneficiary (“MSPB”)
- Episode-based measures

CMS finalized 10 of the proposed 41 episode-based measures:

- Mastectomy
- Aortic/Mitral Valve Surgery
- Coronary Artery Bypass Graft
- Hip/Femur Fracture or Dislocation Treatment, Inpatient-based
- Colonoscopy and Biopsy
- Transurethral Resection of the Prostate for Benign Prostatic Hyperplasia
- Lens and Cataract Procedures
- Hip Replacement or Repair
- Knee Arthroplasty
- Cholecystectomy and Common Duct Exploration

Cost: Attribution

Total Per Capita Cost Measure: Plurality of primary care services by both primary care clinicians and specialists

MSPB Measure: Plurality of Medicare Part B claims (allowed charges) during the index inpatient hospitalization

Episode-Based Measures:

- *For acute episodes*: Attributed to all MIPS eligible clinicians billing ≥30% of inpatient E&M visits during initial treatment (“episode trigger event”)
- *For procedural episodes*: Attributed to all MIPS eligible clinicians billing a Medicare Part B claim with a trigger code during the trigger event of the episode

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Cost: Reporting

Reporting Category	Data Submission Methodology	Data Submission Mechanism
Individual	Each clinician evaluated individually, at TIN/NPI level	Administrative claims (no additional reporting)
Group	Each group evaluated at TIN level	Administrative claims (no additional reporting)
APM Entity *(ALL MIPS APMS)*	N/A—category reweighted to zero	N/A

- No additional reporting for individuals/groups in Cost Category
- Cost measures based on 12 months of data
- Case minimum of 20 for most measures, 35 for MSPB measure

Cost: Scoring

Clinicians/groups will receive 1-10 points for each measure depending on how performance compares to benchmarks

Benchmarks will be derived from performance period data

All measures in category equally weighted

Clinician/group will not be scored on a measure if case minimum of 20/35 is not met

$$\text{Cost Domain Score} = \frac{\text{Sum of all points for reported measures}}{\text{Total possible points}}$$

Special Scoring Considerations

	Non-Patient-Facing Clinicians Clinicians billing 100 or fewer patient-facing encounters (including telehealth); If reporting as a group, more than 75% of clinicians need to meet this definition	Hospital-Based Clinicians Clinicians furnishing 75+% of services in inpatient hospital, ER, or on-campus outpatient hospital settings	Small (<15), Rural, Geographic Health Professional Shortage Area Practices
Quality	**No change**	**No change**	**No Change**
Cost	**No change**	**No change**	**No Change**
Improvement Activities	**Lessened requirements—only 1 or 2 activities needed to achieve maximum score**	**No change**	**Lessened requirements—only 1 or 2 activities needed to achieve maximum score**
Advancing Care Information	**Domain reweighted to zero**	**Domain reweighted to zero**	**Can apply for hardships if applicable**

Non-patient-facing determination:
For 2017 PY, initial period: Sept. 1, 2015—August 31, 2016; second period: Sept. 1, 2016—August 31, 2017

Hospital-based determination:
For 2017 PY, will use claims between Sept. 1, 2015—August 31, 2016

Calculating Final Score

- CMS will apply appropriate weights and aggregate performance category scores
- CMS can reweight categories if clinician/group does not have sufficient applicable measures
- Minimum of 2 performance categories needed to develop final score; otherwise neutral adjustment factor
  - If Advancing Care Information not applicable: 85% Quality, 15% Improvement Activities
  - If Quality not applicable: 50% Advancing Care Information, 50% Improvement Activities

Performance Category	Category Score	Category Weight	Weighted Category Score
Quality	60%	60%	36%
Improvement Activities	100%	15%	15%
Advancing Care Information	60%	25%	15%
Subtotal		**100%**	**66%**
Final Score			**66**

Performance Threshold Comparison

CMS will calculate Performance Threshold ("PT") each year to which each individual final score will be compared—CMS can *arbitrarily* set the PT in 2017 and 2018, but PT will be set at the *median MIPS score* starting in 2019

- If final score < PT, adjustment factor will be negative
- If final score = PT, adjustment factor will be neutral
- If final score > PT, adjustment factor will be positive
- If 0 < final score < ¼ PT, adjustment factor will be maximum negative

Range of Payment Adjustments Fairly Small in 2017

	Final Score Points	MIPS Adjustment
($199 million)	0 - 0.75	-4%
	0.76 - 2.9	Negative MIPS payment adjustment greater than -4% and less than 0% on a linear sliding scale
	3	0%
$199 million	3.1 - 69.9	Positive MIPS payment adjustment ranging from greater than 0% to 4% x scaling factor to preserve budget neutrality, on a linear sliding scale
$500 million	70.0 - 100	Positive MIPS payment adjustment AND additional MIPS payment adjustment for exceptional performance

Application of Payment Adjustment

"The MIPS payment adjustment applies only to the amount otherwise paid under Part B with respect to items and services furnished by a MIPS eligible clinician during a year, in which we will apply the MIPS adjustment at the TIN/NPI level"

MIPS Takeaways

MIPS very easy in 2017 – health systems have more time to strategically prepare for the future

What, and how, should you report in 2017 to maximize 2019 payment adjustments?

Should you consider reorganizing groups or making other strategic decisions to maximize future payment adjustments?

Disclosure

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