2018 Participation in the Merit-based Incentive Payment System (MIPS)

November 7, 2018
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), that provides two participation tracks:

- **MIPS**
  - The Merit-based Incentive Payment System (MIPS)
  - *If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.*

- **Advanced APMs**
  - Advanced Alternative Payment Models (Advanced APMs)
  - *If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.*
What is MIPS?

The Merit-based Incentive Payment System

▲ Combines multiple legacy Medicare Part B programs into a single program

▲ (4) MIPS Performance Categories:
  • Quality (PQRS/Value Modifier-Quality Program)
  • Cost (Value Modifier-Cost Program)
  • Promoting Interoperability (PI) (aka ACI or Medicare MU)
  • Improvement Activities (IA)

*MACRA does not alter or end the Medicaid EHR Incentive Program (Now called the Medicaid Promoting Interoperability Program)
MIPS Year 2 (2018) – Who is Included?

▲ NO CHANGE in the types of clinicians eligible to participate in 2018

▲ MIPS Eligible Clinicians (ECs) include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
MIPS Year 2 (2018) – Who is Included?

▲ As a reminder, the definition of Physician includes:

• Doctor of Medicine
• Doctor of Osteopathy
• Doctor of Dental Surgery
• Doctor of Dental Medicine
• Doctor of Podiatric Medicine
• Doctor of Optometry
• Doctor of Chiropractic Medicine (legally authorized to practice by a State in which he/she performs this function)
MIPS Year 2 (2018) – Who is Included?

▲ Change to the Low-Volume Threshold for 2018. Includes MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowable charges AND providing care for more than 200 Medicare patients a year

▲ Check program eligibility at [https://qpp.cms.gov/participation-lookup](https://qpp.cms.gov/participation-lookup)

Transition Year (2017) Final

Billing
>$30,000

AND

Medicare Patients
>100

Year 2 (2018) Final

Billing
>$90,000

AND

Medicare Patients
>200

Voluntary reporting remains an option for those clinicians who are exempt from MIPS (note – data will still be publically available on Medicare Physician Compare website)
MIPS Year 2 (2018) – Who is Exempt?

▲ Except for the Low-Volume Threshold, no change in basic exemption criteria

Newly-enrolled in Medicare
- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold
- Medicare Part B allowed charges less than or equal to $90,000 a year
  OR
- See 200 or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs
- Receive 25% of their Medicare payments
  OR
- See 20% of their Medicare patients through an Advanced APM
MIPS Year 2 (2018) – Non-Patient Facing

▲ No change in non-patient facing criteria

Transition Year (2017) Final

- **Individual** – If you have \(<= 100\) patient facing encounters.
- **Groups** – If your group has >75% of NPIs billing under your group’s TIN during a performance period are labeled as non-patient facing.

Year 2 (2018) Final

- **No change to individual and group policy**
- **NEW – VIRTUAL GROUPS** are included in the definition.
  - Virtual Groups that have >75% of NPIs within a virtual group during a performance period are labeled as non-patient facing.
## MIPS Year 2 (2018) – Other Special Statuses

<table>
<thead>
<tr>
<th>Special Status</th>
<th>Component</th>
<th>Year 2 (2018) Final</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Practice</td>
<td>Definition</td>
<td>Practices consisting of 15 or fewer billing clinicians</td>
<td></td>
</tr>
<tr>
<td>Rural and Health Professional Shortage Areas (HPSA)</td>
<td>Rural and HPSA practice designations</td>
<td>An individual MIPS eligible clinician, a group, or a virtual group with multiple practices under it’s TIN (or TINs within a virtual group) with more than 75% of NPIs billing under the individual MIPS eligible clinician or group's TIN or within a virtual group in a ZIP code designated as a rural area or HPSA</td>
<td>No change to the application of these special statuses from Year 1 to Year 2</td>
</tr>
</tbody>
</table>
### MIPS Year 2 (2018) – Performance Period

▲ **Change:** Increase in 2 of the 4 Performance Periods

#### Transition Year (2017) Final

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Minimum Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>90-days minimum; 90-365 days was an option</td>
</tr>
<tr>
<td>Cost</td>
<td>Not included. 12-months for feedback only</td>
</tr>
<tr>
<td>Improvement Activities (IA)</td>
<td>90-days</td>
</tr>
<tr>
<td>Promoting Interoperability (PI)</td>
<td>90-days</td>
</tr>
</tbody>
</table>

#### Year 2 (2018) Final

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Minimum Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>12 Months</td>
</tr>
<tr>
<td>Cost</td>
<td>12 Months</td>
</tr>
<tr>
<td>Improvement Activities (IA)</td>
<td>90-days</td>
</tr>
<tr>
<td>Promoting Interoperability (PI)</td>
<td>90-days</td>
</tr>
</tbody>
</table>
MIPS Year 2 (2018) – Reporting Options

OPTIONS

1. Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. As a Group
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year

* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.
Group vs Individual Reporting?

▲ Consider differences in Medicare volume relative to MIPS scores

- If your top performers also bill the most Medicare, group reporting could hurt the bottom line more than individual reporting (top performer scores drop when aggregating scores with lower performers)
- If your lower performers bill the most Medicare, group reporting could be advantageous since their scores will be higher under group reporting (their scores rise due to higher performers)

<table>
<thead>
<tr>
<th>Provider</th>
<th>Medicare Volume</th>
<th>MIPS Scores A</th>
<th>MIPS Scores B</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$500,000</td>
<td>99</td>
<td>10</td>
</tr>
<tr>
<td>B</td>
<td>$500,000</td>
<td>99</td>
<td>20</td>
</tr>
<tr>
<td>C</td>
<td>$200,000</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>D</td>
<td>$150,000</td>
<td>20</td>
<td>99</td>
</tr>
<tr>
<td>E</td>
<td>$100,000</td>
<td>10</td>
<td>99</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment:</th>
<th>Group Reporting</th>
<th>Group Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>= BAD</td>
<td>= GOOD</td>
</tr>
</tbody>
</table>

Group MIPS Score = 55.6
However, from the “Group Participation in the Merit-based Incentive Payment System (MIPS) in 2018” resource on qpp.cms.gov, we know:

<table>
<thead>
<tr>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>A group electing to submit data at the group level would have its performance assessed and scored across the TIN, which could include covered professional services furnished by individual NPIs within the TIN who are not required to participate in MIPS.</td>
</tr>
<tr>
<td>A MIPS eligible clinician participating via a group will get the group’s score. However, if the same MIPS eligible clinician also submits individual level data, CMS will use the higher of the two final scores for that clinician.</td>
</tr>
</tbody>
</table>

So with this in mind, the best overall strategy is:

- **ALWAYS GROUP REPORT** (unless including non-EC provider types negatively affects scores)

Then, if an EC can report individually and his/her individual MIPS Final Score is **better** than the group average, **ALSO** report that clinician’s **individual** data to CMS.

With this strategy:

- Lower performer scores are raised by the higher group score, and
- Higher performers are not negatively affected by lower performers, as CMS will adjust reimbursement rates off their better individual scores instead of the lower group score.
MIPS Year 2 (2018) – Submission Mechanisms

▲ No Change: All of the submission mechanisms remain the same from Year 1 to Year 2

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Mechanisms for Individuals</th>
<th>Submission Mechanisms for Groups (Including Virtual Groups)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>QCDR, Qualified Registry EHR Claims</td>
<td>QCDR, Qualified Registry EHR</td>
</tr>
<tr>
<td>Cost</td>
<td>Administrative claims (no submission required)</td>
<td>Administrative claims (no submission required)</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Attestation QCDR Qualified Registry EHR</td>
<td>Attestation QCDR Qualified Registry EHR</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>Attestation QCDR Qualified Registry EHR</td>
<td>Attestation QCDR Qualified Registry EHR</td>
</tr>
</tbody>
</table>

Please note:

- Continue with the use of 1 submission mechanism per performance category in Year 2 (2018). Same policy as Year 1.
- The use of multiple submission mechanisms per performance category is deferred to Year 3 (2019).
### Basics:

- **Change**: 50% of Final Score in 2018
- 270+ measures available
- You select 6 individual measures
  - 1 must be an Outcome measure
    - OR
  - High-priority measure
- You may also select a specialty-specific set of measures

### Component Table

<table>
<thead>
<tr>
<th>Component</th>
<th>Transition Year 1 (2017) Final</th>
<th>Year 2 (2018) Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight to Final Score</td>
<td>• 60%</td>
<td>• 50%</td>
</tr>
<tr>
<td>Data Completeness</td>
<td>• 50% for submission mechanisms except for Web Interface and CAHPS. Measures that do not meet the data completeness criteria earn 3 points.</td>
<td>• 60% for submission mechanisms except for Web Interface and CAHPS. Measures that do not meet data completeness criteria earn 1 point. <strong>Burden Reduction Aim</strong>: Small practices will continue to receive 3 points.</td>
</tr>
</tbody>
</table>
MIPS Year 2 (2018) – Quality

Basics:
- **Change**: 50% of Final Score in 2018
- 270+ measures available
- You select 6 individual measures
  - 1 must be an Outcome measure
  - OR
  - High-priority measure
- You may also select a specialty-specific set of measures

<table>
<thead>
<tr>
<th>Component</th>
<th>Transition Year 1 (2017) Final</th>
<th>Year 2 (2018) Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoring</td>
<td>3-point floor for measures scored against a benchmark.</td>
<td>No changes</td>
</tr>
<tr>
<td></td>
<td>3 points for measures that do not have a benchmark or do not meet case minimum.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bonus for additional high priority measures up to 10% of denominator for performance category.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bonus for end-to-end electronic reporting up to 10% of denominator for performance category.</td>
<td></td>
</tr>
</tbody>
</table>
Quality Performance Category Considerations

▲ Use your patient population to guide measure selection
   – Pick clinically relevant measures (if you can)
   – What’s important to you and/or aligns with practice goals?
   – Specialty measure sets may not be your best option
   – Registries can also create/use their own measures (aka non-mips measures)
     ▪ Good for Specialists with limited measure options

▲ Low quality measure scores could be caused by:
   – Vendor issues
   – Configuration issues (i.e. LOINC code not properly mapped)
   – Data entry issues
   – Actual “quality” issues

▲ Data submission options matter under the Quality performance category
   – Benchmarks
   – Consider cost of submission option
   – More measure options via “Registry” than “EHR/eCQM”

▲ Topped Out measures
Quality Scores Vary by Submission Method

Formula = \( x + (q-a) / (b-a) \)

Your Performance Rate = 62

<table>
<thead>
<tr>
<th>CLAIMS</th>
<th>EHR</th>
<th>REGISTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \frac{x + (q-a)}{(b-a)} )</td>
<td>( \frac{x + (q-a)}{(b-a)} )</td>
<td>( \frac{x + (q-a)}{(b-a)} )</td>
</tr>
<tr>
<td>5 + (62 - 46.94) / (62.62 - 46.94)</td>
<td>8 + (62 - 52.14) / (63.12 - 52.14)</td>
<td>6 + (62 - 57.07) / (64.78 - 57.07)</td>
</tr>
<tr>
<td>5 + (15.06) / (15.68)</td>
<td>8 + (9.86) / (10.98)</td>
<td>8 + .897</td>
</tr>
<tr>
<td>5 + 0.960</td>
<td>8 + 0.897</td>
<td>6 + .639</td>
</tr>
</tbody>
</table>

Total Points Awarded: 5.96
Total Points Awarded: 8.90
Total Points Awarded: 6.64

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure ID</th>
<th>Submission Method</th>
<th>Decile_3</th>
<th>Decile_4</th>
<th>Decile_5</th>
<th>Decile_6</th>
<th>Decile_7</th>
<th>Decile_8</th>
<th>Decile_9</th>
<th>Decile_10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care &amp; Screening: Influenza Immunization</td>
<td>110</td>
<td>Claims</td>
<td>23.29 - 66.94</td>
<td>33.13 - 46.93</td>
<td>46.94 - 62.62</td>
<td>62.63 - 74.35</td>
<td>74.36 - 86.05</td>
<td>86.06 - 97.34</td>
<td>97.35 - 99.99</td>
<td>100.00</td>
</tr>
<tr>
<td>Preventive Care &amp; Screening: Influenza Immunization</td>
<td>110</td>
<td>EHR</td>
<td>14.55 - 21.83</td>
<td>21.84 - 29.00</td>
<td>29.01 - 36.00</td>
<td>36.00 - 43.53</td>
<td>43.54 - 52.14</td>
<td>52.14 - 63.12</td>
<td>63.13 - 78.42</td>
<td>&gt;= 78.43</td>
</tr>
<tr>
<td>Preventive Care &amp; Screening: Influenza Immunization</td>
<td>110</td>
<td>Registry/CDR</td>
<td>26.89 - 57.07</td>
<td>40.48 - 50.00</td>
<td>50.00 - 57.07</td>
<td>57.07 - 64.78</td>
<td>64.79 - 73.07</td>
<td>73.08 - 82.70</td>
<td>82.71 - 96.43</td>
<td>&gt;= 96.44</td>
</tr>
</tbody>
</table>

x = decile column  
q = your performance rate  
a = low-end of decile column  
b = high-end of decile column
“Topped Out” and “Topped Out Capped” Quality Measures

What is the significance?

- A measure may be considered topped out if meaningful distinctions and improvement in performance can no longer be made.
- Topped out measures could have an impact on the scores for certain MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians.

Topped Out Measures:

- Topped-out measures will be removed and scored on a 4 year phasing out timeline.
- Topped out measures with measure benchmarks that have been topped out for at least 2 consecutive years will receive up to 7 points.
- The 7-point scoring policy for the 6 topped out measures identified for the 2018 performance period is finalized. These measures are identified on the next slide.
- Topped out measures will only be removed after a review of performance and additional considerations.
- Topped out policies do not apply to CMS Web Interface measures, but this will be monitored for differences with other submission options.
“Topped Out Capped” Quality Measures in 2018

**What is the significance?**
- A measure may be considered topped out if meaningful distinctions and improvement in performance can no longer be made.
- Topped out measures could have an impact on the scores for certain MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians.

**Topped Out Measures:**
The six topped out measures include the following:

- Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality Measure ID: 21)
- Melanoma: Overutilization of Imaging Studies in Melanoma. (Quality Measure ID: 224)
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23)
- Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality Measure ID: 262)
- Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description. (Quality Measure ID: 359)
- Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy. (Quality Measure ID: 52)
Be Wary of Using “Topped Out” Quality Measures as Well

▲ **MANY** measures are topped out but not yet capped at 7pts:

<table>
<thead>
<tr>
<th>Submission Method</th>
<th>Measure Type</th>
<th>Benchmark</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
<th>Topped Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>Process</td>
<td>Y</td>
<td>96.11 - 98.73</td>
<td>98.74 - 99.64</td>
<td>99.65 - 99.99</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>100</td>
<td>Yes</td>
</tr>
<tr>
<td>EHR</td>
<td>Process</td>
<td>Y</td>
<td>76.59 - 87.88</td>
<td>87.89 - 92.73</td>
<td>92.74 - 95.35</td>
<td>95.36 - 97.08</td>
<td>97.09 - 98.27</td>
<td>98.28 - 99.12</td>
<td>99.13 - 99.75</td>
<td>&gt;= 99.76</td>
<td>Yes</td>
</tr>
<tr>
<td>Registry/QC/DR</td>
<td>Process</td>
<td>Y</td>
<td>61.27 - 82.11</td>
<td>82.12 - 91.71</td>
<td>91.72 - 96.85</td>
<td>96.87 - 99.31</td>
<td>99.31 - 99.99</td>
<td>--</td>
<td>--</td>
<td>100</td>
<td>Yes</td>
</tr>
</tbody>
</table>

▲ Although not yet “topped out”, scoring options may still be limited:

<table>
<thead>
<tr>
<th>Submission Method</th>
<th>Measure Type</th>
<th>Benchmark</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
<th>Topped Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>Process</td>
<td>Y</td>
<td>11.54 - 30.67</td>
<td>30.68 - 62.08</td>
<td>62.09 - 94.03</td>
<td>94.04 - 99.45</td>
<td>99.46 - 99.99</td>
<td>--</td>
<td>--</td>
<td>100</td>
<td>No</td>
</tr>
<tr>
<td>EHR</td>
<td>Process</td>
<td>Y</td>
<td>1.22 - 2.93</td>
<td>2.94 - 5.93</td>
<td>5.94 - 11.09</td>
<td>11.10 - 17.87</td>
<td>17.88 - 30.29</td>
<td>30.30 - 51.32</td>
<td>51.32 - 72.63</td>
<td>&gt;= 72.64</td>
<td>No</td>
</tr>
<tr>
<td>Registry/QC/DR</td>
<td>Process</td>
<td>Y</td>
<td>2.01 - 5.26</td>
<td>5.27 - 14.88</td>
<td>14.89 - 32.90</td>
<td>32.91 - 50.42</td>
<td>50.43 - 64.99</td>
<td>64.99 - 85.25</td>
<td>85.25 - 99.99</td>
<td>100</td>
<td>No</td>
</tr>
</tbody>
</table>
MIPS Year 2 (2018) – Cost

Basics:
- **Change**: 10% Counted toward Final Score in 2018
- Medicare Spending per Beneficiary (MSPB) and total per capita cost measures are included in calculating Cost performance category score for the 2018 MIPS performance period.
- These measures were used in the Value Modifier and in the MIPS transition year

- **Change**: Cost performance category weight is finalized at 10% for 2018.
- 10 episode-based measures adopted for the 2017 MIPS performance period will not be used.
- We are developing new episode-based measures with significant clinician input and are providing feedback on these measures this fall through field testing.
- This will allow clinicians to see their cost measure scores before the measures are potentially included in the MIPS program.
- We will propose new cost measures in future rulemaking.
MIPS Year 2 (2018) – Cost

**Basics:**
- **Change:** 10% Counted toward Final Score in 2018
- Medicare Spending per Beneficiary (MSPB) and total per capita cost measures are included in calculating Cost performance category score for the 2018 MIPS performance period.
- These measures were used in the Value Modifier and in the MIPS transition year

**Reporting/Scoring:**
- Each individual MIPS eligible clinician’s and group’s cost performance will be calculated using administrative claims data if they meet the case minimum of attributed patients.
- Individual MIPS eligible clinicians and groups are not required to submit any additional information for the cost performance category.
- Performance is compared against performance of other MIPS eligible clinicians and groups during the performance period so benchmark is not based on a previous year.
- Performance category score is the average of the two measures: Medicare Spending per Beneficiary (MSPB) and total per capita cost measures.
- If only one measure can be scored, it will serve as the performance category score.
Cost Performance Category Considerations

▲ Worth 10% in 2018 but will increase over time until worth 30% of MIPS Final Score

▲ This year’s cost category score is the average of:
  ▪ Medicare Spending per Beneficiary (MSPB) measure (35+ episodes needed), and
  ▪ Total per Capita Cost (TPCC) measure (20+ episodes needed)
    – If only one can be scored for an EC, it will serve as the category score
    – If neither can be scored, the 10% weight is added to Quality, making it worth 60%

▲ Although not scored in 2017, CMS provided feedback to assist in 2018
  – Note: 2018 comparison for scoring done in same performance year, not previous year benchmarks

▲ Prior data can also be found on PQRS/Quality Resource Use Report (QRUR) which can be accessed via QualityNet.org (practice level, not provider level data)

▲ “Double dip” by choosing related quality measures so improvements there also affect your cost performance category

▲ Keep in mind, with only a 10% weight in 2018, a significant/notable 10% increase in the category will only amount to a 1% increase in MIPS Final Score. Until it’s worth more (and we know more), improvement efforts may be better focused in areas with greater impact
**Basics:**
- 15% of Final Score in 2018
- 112 activities available in the inventory
  - Medium and High Weights remain the same from Year 1
  - Medium = 10 points
  - High = 20 points
- A simple “yes” is all that is required to attest to completing an Improvement Activity

**Number of Activities:**
- No change in the number of activities that MIPS eligible clinicians must report to achieve a total of 40 points.
- **Burden Reduction Aim:** MIPS eligible clinicians in small practices and practices in a rural areas will continue to report on no more than 2 activities to achieve the highest score.

**Patient-centered Medical Home:**
- We finalized the term “recognized” is equivalent to the term “certified” as a patient centered medical home or comparable specialty practice.
- 50% of practice sites* within a TIN or TINs that are part of a virtual group need to be recognized as patient-centered medical homes for the TIN to receive the full credit for Improvement Activities in 2018.
MIPS Year 2 (2018) – Improvement Activities

**Basics:**
- 15% of Final Score in 2018
- 112 activities available in the inventory
  - Medium and High Weights remain the same from Year 1
  - Medium = 10 points
  - High = 20 points
- A simple “yes” is all that is required to attest to completing an Improvement Activity

**Additional Activities:**
- We are finalizing additional activities, and changes to existing activities for the Improvement Activities Inventory including credit for using Appropriate Use Criteria (AUC) through a qualified clinical support mechanism for all advanced diagnostic imaging services ordered.

**Scoring:**
- Continue to designate activities within the performance category that also qualify for an Advancing Care Information performance category bonus.
- For group reporting, only one MIPS eligible clinician in a TIN must perform the Improvement Activity for the TIN to receive credit.
- For virtual group reporting: only one MIPS eligible clinician in a virtual group must perform the Improvement Activity for the TIN to receive credit.
- Continue to allow simple attestation of Improvement Activities.
MIPS Year 2 (2018) – Advancing Care Information...Now “Promoting Interoperability” (PI)

Basics:
- 25% of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition.

CEHRT Requirements:
- **Burden Reduction Aim**: MIPS eligible clinicians may use either the 2014 or 2015 CEHRT or a combination in 2018.
- A **10% bonus** is available for using only 2015 Edition CEHRT.

Measures and Objectives:
- CMS finalizes exclusions for the E-Prescribing and Health Information Exchange Measures.

Scoring:
- No change to the base score requirements for the 2018 performance period/2020 payment year.
- For the performance score, MIPS eligible clinicians and groups will earn 10% for reporting to any one of the Public Health and Clinical Data Registry Reporting measures as part of the performance score.
- For the bonus score a 5% bonus score is available for reporting to an additional registry not reported under the performance score.
- Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus for completion of at least 1 of the specified Improvement Activities using CEHRT.
Exclusions:

- Based on authority granted by the 21st Century Cures Act and MACRA, CMS will reweight the Advancing Care Information performance category to 0 and reallocate the performance category weight of 25% to the Quality performance category for the following reasons:

Automatic reweighting:
- Hospital-based MIPS eligible clinicians;
- Ambulatory Surgical Center (ASC)–based MIPS eligible clinicians, finalized retroactive to the transition year;
- Nurse practitioners, physician assistants, clinical nurse specialist, certified registered nurse anesthetists

Reweighting through an approved application:
- **New hardship exception for clinicians in small practices** (15 or fewer clinicians);
- New decertification exception for eligible clinicians whose EHR was decertified, retroactively effective to performance periods in 2017.
- Significant hardship exceptions—CMS will not apply a 5-year limit to these exceptions;

- **New deadline of December 31** of the performance year for the submission of hardship exception applications for 2017 and future years.

- Revised definition of hospital-based MIPS eligible clinician to include covered professional services furnished by MIPS eligible clinicians in an off-campus outpatient hospital (POS 19).
Promoting Interoperability (PI) Performance Category Scoring

Base Score + Performance Score + Bonus Points = Category Score

- Earns 50 POINTS of the total Promoting Interoperability Performance Category Score
- Makes up to 90 POINTS of the total Promoting Interoperability Performance Category Score
- Earn up to an add’l 25 POINTS in the total Promoting Interoperability Performance Category Score
- Earn 100 or more points and receive the full 25 POINTS in the Promoting Interoperability Category of the MIPS Final Score
<table>
<thead>
<tr>
<th>Base Score</th>
<th>2018 PI/ACI “Transition” Objectives</th>
<th>2018 PI/ACI “Regular” Objectives (2015 CEHRT/Stage 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>eRx</td>
<td>eRx</td>
<td>Send Summary of Care (Patient Care Record Exchange)</td>
</tr>
<tr>
<td>Health Information Exchange (Create/Send Summary of Care)</td>
<td></td>
<td>Request Summary of Care (Patient Care Record)</td>
</tr>
<tr>
<td>Security Risk Analysis</td>
<td></td>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td>Provide Patient Access (Patient Access)</td>
<td></td>
<td>Provide Patient Access (Patient Access)</td>
</tr>
</tbody>
</table>
## Promoting Interoperability (PI) Performance Score

### Performance Score

- Makes up to **90 POINTS** of the total Promoting Interoperability Performance Category Score

<table>
<thead>
<tr>
<th>2018 PI/ACI Transition Objectives</th>
<th>2018 PI/ACI “Regular” Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Patient Access</td>
<td>Provide Patient Access</td>
</tr>
<tr>
<td>View Download Transmit</td>
<td>View Download Transmit</td>
</tr>
<tr>
<td>Patient-specific Information</td>
<td>Patient-specific Information</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Secure Messaging</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Send a Summary of Care</td>
</tr>
<tr>
<td></td>
<td>Request/Accept a Summary of Care</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Clinical Information Reconciliation</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>Public Health Reporting</td>
</tr>
<tr>
<td></td>
<td>Patient-generated Health Data</td>
</tr>
</tbody>
</table>

- **Provide Patient Access**: 20 pts
- **View Download Transmit**: 10 pts
- **Patient-specific Information**: 10 pts
- **Secure Messaging**: 10 pts
- **Health Information Exchange**: 20 pts
- **Medication Reconciliation**: 10 pts
- **Public Health Reporting**: 10 pts
- **Patient-generated Health Data**: 10 pts
Calculating Promoting Interoperability Performance

How is the Performance Score Calculated?

▲ The performance score is calculated by using the numerators and denominators submitted for measures included in the performance score, or for one measure, by the yes or no answer submitted.

▲ The potential total performance score is 90%. For each measure with a numerator/denominator, the percentage score is determined by the performance rate. Most measures are worth a maximum of 10 percentage points, except for two measures reported under the 2018 Transition Measures, which are worth up to 20 percentage points.

<table>
<thead>
<tr>
<th>Performance Rates for Each Measure Worth Up to 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Rate 1-10 = 1%</td>
</tr>
<tr>
<td>Performance Rate 11-20 = 2%</td>
</tr>
<tr>
<td>Performance Rate 21-30 = 3%</td>
</tr>
<tr>
<td>Performance Rate 31-40 = 4%</td>
</tr>
<tr>
<td>Performance Rate 41-50 = 5%</td>
</tr>
<tr>
<td>Performance Rate 51-60 = 6%</td>
</tr>
<tr>
<td>Performance Rate 61-70 = 7%</td>
</tr>
<tr>
<td>Performance Rate 71-80 = 8%</td>
</tr>
<tr>
<td>Performance Rate 81-90 = 9%</td>
</tr>
<tr>
<td>Performance Rate 91-100 = 10%</td>
</tr>
</tbody>
</table>

Example: If a MIPS eligible clinician submits a numerator and denominator of 85/100 for the Patient-Specific Education measure, their performance rate would be 85%, and they would earn 9 out of 10 percentage points for that measure.
Calculating the “Base” PI Category Score

<table>
<thead>
<tr>
<th>BASE MEASURES</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Performance Score</th>
<th>Threshold</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>eRx</td>
<td>2718</td>
<td>2827</td>
<td>96%</td>
<td>Numerator ( \geq ) 1 Patient</td>
<td>YES</td>
</tr>
<tr>
<td>VDT - Access</td>
<td>429</td>
<td>432</td>
<td>99%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>HIE/SoC</td>
<td>21</td>
<td>83</td>
<td>25%</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>SRA</td>
<td>N/A</td>
<td>N/A</td>
<td>YES</td>
<td>Yes/No</td>
<td>YES</td>
</tr>
</tbody>
</table>

**TOTAL BASE SCORE** 50%
Calculating the “Performance” PI Category Score

<table>
<thead>
<tr>
<th>PERFORMANCE MEASURES</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Performance Score</th>
<th>Decile Score</th>
<th>Performance Weighting</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIE/SoC</td>
<td>21</td>
<td>83</td>
<td>25%</td>
<td>3</td>
<td>Up to 20%</td>
<td>6%</td>
</tr>
<tr>
<td>VDT - Access</td>
<td>429</td>
<td>432</td>
<td>99%</td>
<td>10</td>
<td>Up to 20%</td>
<td>20%</td>
</tr>
<tr>
<td>VDT - Use</td>
<td>186</td>
<td>432</td>
<td>43%</td>
<td>5</td>
<td>Up to 10%</td>
<td>5%</td>
</tr>
<tr>
<td>Patient Education</td>
<td>418</td>
<td>432</td>
<td>97%</td>
<td>10</td>
<td>Up to 10%</td>
<td>10%</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>307</td>
<td>332</td>
<td>92%</td>
<td>10</td>
<td>Up to 10%</td>
<td>10%</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>31</td>
<td>432</td>
<td>7%</td>
<td>1</td>
<td>Up to 10%</td>
<td>1%</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>N/A</td>
<td>N/A</td>
<td>YES</td>
<td>N/A</td>
<td>0 or 10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

TOTAL PERFORMANCE SCORE: 62%
## Calculating the Overall PI Category Score

<table>
<thead>
<tr>
<th>BONUS MEASURES</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Performance Rate</th>
<th>Performance Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Public Health Reporting</td>
<td>N/A</td>
<td>N/A</td>
<td>YES</td>
<td></td>
<td>5%</td>
</tr>
<tr>
<td>Report “Regular” PI Measures using only 2015 CEHRT</td>
<td>N/A</td>
<td>N/A</td>
<td>NO</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>Report Specific IA using CEHRT (See Fact Sheet for List)</td>
<td>N/A</td>
<td>N/A</td>
<td>NO</td>
<td></td>
<td>10%</td>
</tr>
</tbody>
</table>

**TOTAL BONUS SCORE** 5%

### Scoring Example Totals:

- **Base** 50%
- **Performance** 62%
- **Bonus** 5% *(often not needed for max PI score)*

**Total PI Score:** 117%, capped at 100%

**EC would earn the maximum 25 PI points towards total MIPS Final Score**
MIPS Year 2 (2018) – Performance Threshold & Payment Adjustments

▲ Change: Increase in Performance Threshold and Payment Adjustment

Transition Year (2017) Final

- 3 Point Threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

Year 2 (2018) Final

- 15 Point Threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

How can an EC/Group achieve 15 points?

▲ Report all required Improvement Activities to get full category points (15pts)
▲ Meet the PI base score (12.5pts) and submit 1 Quality measure that meets data completeness (2.5pts)
▲ Meet the PI base score (12.5pts) and submit 1 medium-weight Improvement Activity (7.5pts)
▲ Submit 6 Quality measures that meet data completeness criteria (15pts)
### Transition Year (2017) Final

<table>
<thead>
<tr>
<th>Final Score 2017</th>
<th>Payment Adjustment 2019</th>
</tr>
</thead>
</table>
| ≥70 points       | • Positive adjustment  
                  | • Eligible for exceptional performance bonus—minimum of additional 0.5% |
| 4-69 points      | • Positive adjustment  
                  | • Not eligible for exceptional performance bonus |
| 3 points         | • Neutral payment adjustment |
| 0 points         | • Negative payment adjustment of -4%  
                  | • 0 points = does not participate |

### Year 2 (2018) Final

<table>
<thead>
<tr>
<th>Final Score 2018</th>
<th>Change Y/N</th>
<th>Payment Adjustment 2020</th>
</tr>
</thead>
</table>
| ≥70 points       | N          | • Positive adjustment greater than 0%  
                  |                         | • Eligible for exceptional performance bonus—minimum of additional 0.5% |
| 15.01-69.99 points | Y          | • Positive adjustment greater than 0%  
                  |                         | • Not eligible for exceptional performance bonus |
| 15 points        | Y          | • Neutral payment adjustment |
| 3.76-14.99 points | Y          | • Negative payment adjustment greater than -5% and less than 0% |
| 0-3.75 points    | Y          | • Negative payment adjustment of -5% |
MIPS Year 2 (2018) – Calculating the Final Score

Quality + Cost + Improvement Activities + Promoting Interoperability = 100 Possible Final Points

Remember: All of the performance category points are added together to give you a MIPS Final Score.

The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a positive, negative, or neutral payment adjustment.
MIPS Year 2 (2018) – Scoring Improvements

▲ New: MIPS Scoring Improvement for Quality and Cost* Performance Categories

- For Quality:
  - Improvement scoring will be based on the rate of improvement such that higher improvement results in more points for those who have not previously performed well.
  - Improvement will be measured at the performance category level.
  - Up to 10 percentage points available in the Quality performance category.

- For Cost:
  - Improvement scoring will be based on statistically significant changes at the measure level.
  - Up to 1 percentage point available in the Cost performance category.

*Bipartisan Budget Act of 2018 altered 2018 QPP rules
MIPS Year 2 (2018) – Complex Patient Bonus

▲ New: Complex Patient Bonus

- Up to 5 bonus points available for treating complex patients based on medical complexity.
  - As measured by Hierarchical Condition Category (HCC) risk score and a score based on the percentage of dual eligible beneficiaries.

- MIPS eligible clinicians or groups must submit data on at least (1) performance category (Quality, PI or IA) in an applicable performance period to earn this bonus. Automatic scoring of Cost performance category by CMS does not count.
MIPS Year 2 (2018) – Small Practice Bonus

▲ New: Small Practice Bonus

- **5 bonus points** added to the final score of any MIPS eligible clinician or group who is in a small practice (15 or fewer billing clinicians), so long as the MIPS eligible clinician or group submits data for at least (1) performance category (Quality, PI or IA) in an applicable performance period. Automatic scoring of Cost performance category by CMS does not count.

**Burden Reduction Aim:**

- CMS recognizes the challenges of small practices and will provide a 5 point bonus to help them successfully meet MIPS requirements
FREE Technical Assistance – Available Resources and Organizations

**PRIMARY CARE & SPECIALIST PHYSICIANS**
Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative, and peer-based learning networks over 4 years.
- Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs) are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPQICSTeam@slhbm.com for extra assistance.

*Locate the PTN(s) and SAN(s) in your state*

**SMALL & SOLO PRACTICES**
Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
- For more information or for assistance getting connected, contact QPSURS@IMPAQINT.COM.

**LARGE PRACTICES**
Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in large practices (more than 15 clinicians) in meeting Merit-Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

*Locate the QIN-QIO that serves your state*

**TECHNICAL SUPPORT**
All Eligible Clinicians Are Supported By:

- **Quality Payment Program Website:** qpp.cms.gov
  Serves as a starting point for information on the Quality Payment Program.

- **Quality Payment Program Service Center**
  Assists with all Quality Payment Program questions.
  1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

- **Center for Medicare & Medicaid Innovation (CMMI) Learning Systems**
  Helps clinicians share best practices for success, and more through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Go to [www.qppresourcecenter.org](http://www.qppresourcecenter.org) and click “Join Now”
Questions?

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