10 FAQs About the Merit-based Incentive Payment System (MIPS) – Updated for 2018

Prelude

Our approach for these FAQs is two-fold. First, we attempt to explain in one narrative the key aspects of MIPS, as updated for the 2018 performance year, both for those new to the program as well as those with previous experience and familiarity with the 2017 MIPS rules. The FAQs are optimally read in sequential order, but are also sufficiently standalone (with linking across FAQs) to enable skipping to the one of greatest interest. Second, we reference or reproduce curated key excerpts from original CMS source documents, such as Federal Register regulatory rules and CMS fact sheets. In this manner, we enable

readers to more quickly and easily explore a topic in greater depth based on the source-of-truth CMS document.

On November 2, 2017, CMS released the 2018 Quality Payment Program (QPP) final rule (easier-to-read format here) in accordance with one of the most bipartisan and significant legislative changes to Medicare in a generation, the Medicare Access and CHIP Re-authorization Act of 2015 (MACRA). MACRA repeals the legacy Medicare Part B Sustainable Growth Rate (SGR) reimbursement formula and replaces it with the QPP, a new value-based reimbursement system impacting Part B payments to clinicians nationally. The QPP consists of two major tracks:

- The Merit-based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)

CMS predicts that 600,000 Part B clinicians will be subject to MIPS in 2018, as MIPS is effectively the "new default" for Part B where clinicians are excluded from MIPS only under certain conditions.

Additionally, in February 2018, Congress passed the Bipartisan Budget Act of 2018 which made some modifications to the MIPS program for 2018 and future years, including the extension of the MIPS transition period another three years until 2022.

Read on for some of the most frequently asked questions about 2018 MIPS. You may also consult our archived 2017 MIPS FAQs.

1. What is MIPS?

MIPS is currently CMS' largest value-based care (VBC) payment program, and a major catalyst towards transforming the healthcare industry from fee-for-service to pay-for-value. MIPS also serves as the primary stepping stone for provider organizations to graduate to APMs operated by CMS. Tenets of the MIPS program have been adopted by other value-based programs. For example, all Advanced APMs must adopt quality measures comparable to those approved for MIPS, and Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) are rated on their compliance with the MIPS Advancing Care Information (ACI) performance category. In 2018, more than half-a-million clinicians' 2017 MIPS scores will be publicly published by CMS, further expanding the program's influence on the industry's shift towards value-based care.

MIPS annually scores eligible Medicare Part B clinicians on a 100-point performance scale which combines and expands upon the legacy Medicare Meaningful Use (MU), Physician Quality Reporting System (PQRS), and Value-Based Modifier (VBM) programs. MIPS adjustments to a clinician's Part B payments are based upon the MIPS performance score and applied to the Medicare payment for every Part B item and service billed by the clinician two years after the performance year, e.g. 2019 is the payment adjustment year for the 2017 performance year. A significant portion of the incentive pool is derived from the penalties applied to poor performers, effectively making MIPS a program where the winners earn rewards at the expense of the losers.

Year-over-year, MIPS increases the level of competition among provider organizations, and raises the financial and reputational impacts to clinicians. CMS and Congress (through the Bipartisan Budget Act) have exercised their authority under MACRA to make the MIPS transition more gradual, allowing CMS to set certain program variables such as the Cost performance category weight to vary between 10% and 30%.

The Bipartisan Budget Act mandates that CMS must gradually increase the MIPS performance threshold each year towards becoming the national historical mean or median in the 2022 performance year. For this reason, MIPS can be likened to a "treadmill" which speeds up over time, motivating organizations and clinicians to keep or exceed the pace of competition.

Note that MIPS does not impact the Medicaid Meaningful Use nor eligible hospital Meaningful Use programs. As a result, some clinicians may be subject to both MIPS and the Medicaid Meaningful Use program. This is but one example of a clinician being subject to multiple value-based care programs, either from a single payer or across multiple payers.

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2. What are the financial and reputational impacts of MIPS?

Overview of Financial Impacts

MACRA defines two types of financial impacts for Medicare Part B clinicians participating in MIPS:

- A small, annual inflationary adjustment to the Part B fee schedule
- MIPS value-based payment adjustments (incentives or penalties) based on the MIPS 100-point final score

The Medicare Part B inflationary adjustment is an annual +0.5% increase for the payment years 2016 to 2019, which is the first payment year for MIPS associated with the first performance year (2017). There is no inflationary adjustment from 2020 to 2025. A subsequent annual inflationary adjustment of +0.25% applies to the payment year 2026 and thereafter.

The potential MIPS incentives and penalties driven by the MIPS score are much more substantial than the inflationary adjustments. The following table shows the top-to-bottom Part B payment adjustment impact range in the initial program years:

MIPS Payment Adjustments: Maximum Impact Range

Performance Year	Medicare Part B Payment Adjustment Year	Maximum -% MIPS Penalty	Maximum +% MIPS Base Incentive	Maximum +% MIPS Exceptional Performance Bonus
2017	2019	-4%	+4%*X (CMS predicts 0.86%)	+10%*Y (CMS predicts 1.52%)
2018	2020	-5%	+5%*X (CMS predicts 0.30%)	+10%*Y (CMS predicts 1.75%)
2019	2021	-7%	+7%*X	+10%*Y
2020	2022	-9%	+9%*X	+10%*Y
2021	2023	-9%	+9%*X	+10%*Y
2022	2024	-9%	+9%*X	+10%*Y

**See explanation below. Assumes number of penalized clinicians is approximately equal to the number of clinicians earning incentives.*

The maximum penalty increases to 9% of Part B payments for the 2020 performance year. The maximum incentive is the sum of a maximum base incentive and a maximum exceptional performance bonus, which

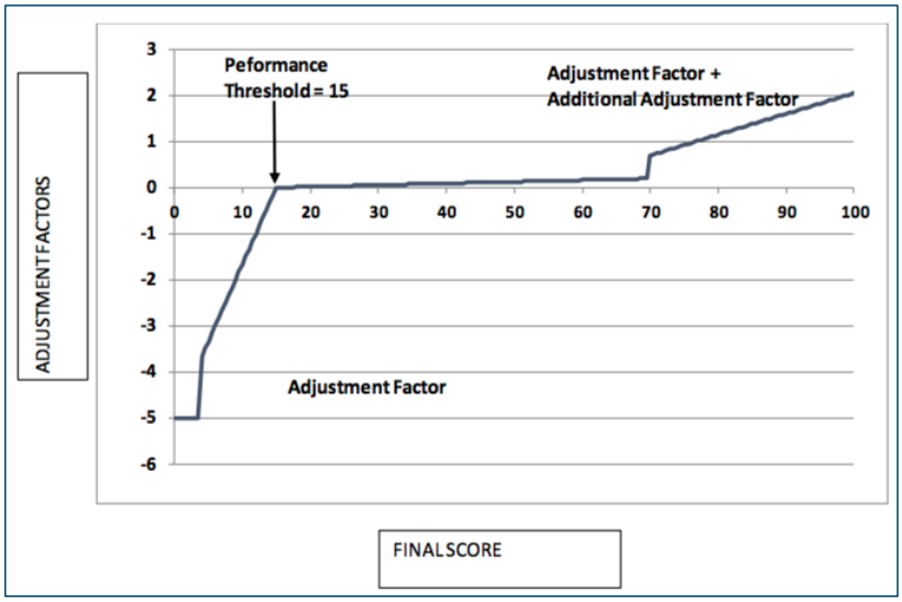
depend on respective scaling factors, X and Y. We explain below how the predictions and estimates shown in the table were derived.

CMS calculates X (the "budget-neutrality factor") such that the national base incentive pool is set equal to the national penalty dollars assessed. Through this mechanism, those earning incentives are effectively being paid by those receiving penalties for substandard performance. X is capped at 3.0, such that the theoretical maximum incentive for the 2020 performance year would be +9% * 3.0 = 27%. Due to the authority MACRA grants CMS to make it easier to avoid penalties for the initial 2017 and 2018 performance years, CMS predicts relatively low maximum incentives of 2.38% and 2.05%, respectively (references: 2017 and 2018 QPP Final Rules). Additionally, the Bipartisan Budget Act of 2018 extended the transition period through 2021. However, given the MACRA rules for benchmarking MIPS in the 2022 performance year, it is reasonable to expect that X will be approximately 1.0 in that year (the situation where the number of penalized clinicians roughly equals the number clinicians earning incentives), which would yield a ~ 9% maximum base incentive for 2022 performance.

CMS calculates Y by allocating $500M per year (available each year through 2022) to an exceptional performance bonus pool for high performers based on scoring rules described further below. As shown in the table above, CMS predicts Y = 0.175 for the 2018 performance year, yielding a maximum exceptional performance bonus of 1.75%. Furthermore, CMS predicts that 74% of 600,000 MIPS eligible clinicians (444,000 clinicians) will earn an exceptional performance bonus (minimum of 0.5%) for 2018 performance.

Translating MIPS Scores into Payment Adjustments

To illustrate the precise relationship between MIPS scores and Medicare Part B payment adjustments, the 2018 QPP Final Rule ("Figure A") contains CMS' projection for how MIPS scores will translate into Medicare Part B payment adjustments for the 2018 performance year and associated 2020 payment year:



2018 QPP Final Rule, Figure A, p809

For each performance year, CMS sets a performance threshold (PT) number of points at which a provider earning PT points receives 0% adjustment to their Medicare Part B payments – no penalty, no incentive. As shown in the Figure A, CMS has set PT = 15 points for 2018. In the slanted parts of the adjustment line, every incremental tenth-of-a-point corresponds to a proportional change in payment adjustment. The

maximum penalty is assessed if a clinician scores below ¼ of PT (equal to 3.75 points for 2018). On the other hand, if a clinician scores at or above the exceptional performance bonus threshold (EPBT; set to 70 for 2018, as seen in Figure A), then the exceptional bonus is applied in proportion to the amount by which the MIPS score exceeds the EPBT.

For the 2018 performance year, one can see from Figure A that the incentives are modest. The MACRA legislation allows CMS to arbitrarily set the PT and EPBT for the new "transition years" through 2021. In 2022, by law the PT must be raised to equal the historical mean or median of scores nationally.

In the 2018 QPP Final Rule, **CMS predicts that 74% of MIPS-eligible clinicians will earn a score of 70 or greater for the 2018 performance year.** This bolsters the expectation that the PT for 2019 will be much higher than for 2018, perhaps into the 70s, thereby significantly raising the level of competition for incentives and avoiding penalties. In addition, **CMS projects for 2018 that 76% of all MIPS-eligible clinicians will be in provider organizations of 25 clinicians or more.** Hence, the main competition to exceed the PT will be among medium and large organizations and will intensify each year. Organizations intent on maximizing their chances for sustainable success under MIPS are leveraging predictive analytics to understand performance by clinician and taking steps to implement performance improvement activities in line with multi-year plans and strategies for success in value-based care.

To deliver a deeper understanding of the financial mechanics of MIPS as it applies to your unique environment, we provide a free MIPS financial calculator for analyzing the impacts of different scenarios and assumptions on predicted MIPS payment adjustments.

Reputational Impacts

CMS publishes an array of clinician-identifiable performance measures through its Physician Compare website for consumers to browse and third-party physician rating websites to procure for free. As consumers spend more out-of-pocket for their healthcare, they are seeking more transparency into clinician quality and the cost-value equation. A study found that 65% of consumers are aware of online physician rating sites and that 36% of consumers had used a ratings site at least once[1]. In addition, 3rd-party consumer rating sites have found high correlations between revenues and consumer ratings. For instance, a 1-star difference on a 5-star rating scale on Yelp drives a 5% to 9% difference in service provider revenues[2] due to impacts on customer acquisition. For a given change in provider performance in a value-based program such as MIPS, this level of revenue impact due to the influence of publicly-reported scores on consumer choice can be much larger than that due to payer reimbursement variations[3].

MACRA requires CMS to publish each eligible clinician's annual MIPS score and performance category scores within approximately 12 months after the end of the relevant performance year. Consequently, more than half-a-million CY2017 MIPS scores will be publicly available around the end of CY2018, all identifiable by clinician and group. Consumers will be able to clearly see their clinicians rated against national peers on a scale of 0 to 100. In addition, the 2018 QPP Final Rule states that a 5-star rating scale will be applied to every MIPS performance measure for purpose of peer comparisons.

Although MIPS financial adjustments can change annually based on clinician performance, damage to a clinician's online public reputation may take years to reverse. Conversely, high publicly-reported scores can become a persistent strategic advantage over competitors.

The Score Follows the Clinician

The financial and reputational impacts stemming from the MIPS score are irrevocably attached to a clinician, even if the clinician changes organizations. If a clinician earns a MIPS score for 2018 and moves to another organization in 2019, the new organization will inherit the MIPS payment adjustment applied in 2020 based on the 2018 score earned by the clinician at the previous organization. This fact impacts how organizations should credential and contract with clinicians, and may impact an organization's ability to attract the best and brightest if group scores are not competitive. In addition, every historical MIPS score earned by a clinician is a permanent part of the publicly-reported record released and maintained by CMS, effectively making MIPS scores an increasingly significant portion of a clinician's resume.

[1]JAMA, 2014; 311(7):734-735.

[2]The Impact of Online Reviews on Customers' Buying Decisions, July 2015

[3]The ABCs of MIPS: The Hidden Impacts of MIPS, May 18, 2017.

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3. Who is subject to MIPS?

MIPS eligibility includes only those eligible clinicians in the categories below who bill for Medicare Part B (otherwise known as the Physician Fee Schedule) or Critical Access Hospital (CAH) Method II payments assigned to the CAH.

The eligibility net expands over the first several years as follows:

- **2017 and 2018 performance years:** physicians (MD/DO and DMD/DDS), physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists
- **2019+ performance years:** expanded to physical and occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and dietitians/nutritional professionals (as proposed and may be modified in the 2019 QPP Final Rule)
- **Payments excluded from MIPS payment adjustments:**
    - Medicare Part A
    - Medicare Advantage Part C
    - Medicare Part D
    - CAH Method I facility payments
    - Federally qualified health center (FQHC), rural health clinic (RHC), ambulatory surgical center (ASC), home health agency (HHA), hospice, or hospital outpatient department (HOPD) facility payments billed under the facility's all-inclusive payment methodology or prospective payment system methodology
- **Applicable payments:** For performance year 2017, Part B payments subject to MIPS payment adjustments include services and items (such as Part B drugs). However, the Bipartisan Budget Act changed the applicable payments to include only services for performance years 2018+.

Exclusions from MIPS

For the 2018 performance year, and for individual clinicians or groups of clinicians billing through a common tax identification number (TIN) meeting the above eligibility criteria, there are only three exclusions from MIPS:

- Clinicians in their first calendar year of Medicare Part B participation
- Clinicians billing $90,000 or less in Medicare Part B allowed charges or providing care for 200 or fewer Part B beneficiaries in a 12 month period (for performance year 2017, allowed charges include for services and items; for 2018+, allowed charges include for services only.)
- Clinicians in entities sufficiently participating in an Advanced APM (see our APM FAQs)

MIPS APM Clinicians

Some clinicians who participate in an APM are also subject to MIPS. For example, Advanced APM clinicians not "sufficiently participating" in their APM entity are also subject to either standard MIPS or, if the APM design meets certain conditions deeming the APM a "MIPS APM", a special version of MIPS. A common example of a MIPS APM is the Medicare Shared Savings Program (MSSP), under which MSSP Track 1 clinicians are also subject to MIPS scoring and reporting requirements. See our APM FAQs to learn more.

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4. What determines a clinician's MIPS score?

A clinician's annual MIPS score of up to 100 points is determined by four categories of clinician performance and bonus point opportunities. See below for the 2018 performance year, and associated 2020 payment adjustment year: Quality (50% weight, or 50 MIPS points maximum)

- Cost (10% weight, or 10 MIPS points maximum)
- Advancing Care Information (ACI) (25% weight, or 25 MIPS points maximum)
- Improvement Activities (IA) (15% weight, or 15 MIPS points maximum)
- Small Practice Bonus (5 MIPS points)
- Complex Patient Bonus (5 MIPS points maximum)

Should the total points earned be greater than 100 points, a 100-point cap would be applied. Under certain conditions, a clinician may be exempt from a performance category, which then triggers the available points from that category to be reallocated to one or more of the other categories. Note that re-weighting of categories occurs under these circumstances.

The MIPS score earned by a clinician for the performance year determines the percentage adjustment applied to every Medicare Part B payment to the clinician in the payment adjustment year, which is the second calendar year after the performance year. About 9 months after the performance year ends, CMS delivers a MIPS feedback report to each clinician or group of clinicians containing the official MIPS score calculated for that performance year. At this time, healthcare organizations have a clear sense of payment adjustments, and consumers can see performance scores.

Individual-Clinician Versus Group Scoring

For each performance year, a provider organization may choose to report MIPS data for clinicians individually or as a group of clinicians billing Part B through a common tax identification number (TIN). This decision must apply equally across all MIPS categories for a given performance year, such that a clinician cannot choose to be subject as an individual in some categories while relying on a group for other categories. The decision to report as a group or by individual clinicians has financial and reputational ramifications that should be considered in association with the organizations culture and strategy.

Group Reporting:

- Groups must consist of at least 2 clinicians who have assigned their Medicare Part B billing rights to the TIN, and at least one clinician must be individually eligible for MIPS.
- Performance data for each category is submitted as a group, impacting the ability for individual over achievers to differentiate themselves by reporting higher performance overall, or on measures that may be more applicable to their specialty.
- Each TIN receives a single MIPS score, and every clinician billing Part B through that TIN inherits the group's MIPS score.
- MIPS payment adjustments are applied to each TIN/NPI combination based on the group score.
- An organization must submit data from all the clinicians in the group, including clinicians who are otherwise excluded from MIPS individually due to low volume, newly Medicare enrolled status or QP status from an Advanced APM.
- In some cases, individual ACI data can be optionally included or excluded from Group reporting for some clinician types such as non-patient facing or hospital-based clinicians. Their data must be included in the other categories for group reporting but, due to the nature of their clinician-type, the group can choose to remove them from the TIN level data.

Virtual Groups:

- Practices each with up to 10 clinicians may together form a "virtual group" for purpose of earning and submitting data for a collective MIPS score.
- The vast majority of MIPS group scoring rules apply to virtual groups.
- The deadline for applying to CMS to form a 2018 virtual group is/was December 31, 2017.

Individual Reporting:

- Each clinician is identified by a unique combination of national provider identification number (NPI) and the TIN through which the clinician bills Part B.
- Clinicians billing through two different TINs receive two MIPS scores and separate payment adjustments for each TIN/NPI combination.
- Submitting performance data by individual clinician emphasizes individual accountability, which may be preferred by specialty providers who want to differentiate themselves, or by organizations who are organizing in this way.

The choice of whether to report clinicians individually or as a group for MIPS can greatly affect the financial and reputational impacts of MIPS. For instance, the overall MIPS adjustment to an organization's Part B revenues can be dramatically different due to the ability to select unique quality measures under individual reporting, versus the same measures for all clinicians under group reporting. In terms of public reputation, individual reporting exposes a clinician's individually-earned MIPS score to consumers, whereas all

clinicians inherit the same MIPS score under group reporting. The distribution of individual-clinician performance, organizational appetite for consumer transparency, and organizational culture all weigh into which option is best.

Bonus Points for the 2018 Performance Year

In the 2018 QPP Final Rule, CMS is recognizing risk factors incurred by clinicians for caring for complex patients or working in small practices. CMS created "short-term solutions" rendered in the form of bonuses for the 2018 performance year, and will re-evaluate the need for these bonuses based upon the development of longer-term solutions within MIPS for recognizing these types of risks.

Short-term solutions and bonuses:

- Clinicians billing Medicare Part B through a TIN deemed by CMS to be a small practice with 15 or fewer clinicians will automatically receive 5 bonus MIPS points. CMS will notify organizations of their small practice status for the 2018 performance year by spring of 2018.
- CMS will award up to 5 bonus MIPS points proportional to the level of clinical complexity and risk of a clinician's patient population. The bonus is based upon Hierarchical Condition Category (HCC) risk scores and socio-economic risk as measured based upon the proportion of patients with dual Medicare-Medicaid eligibility. CMS estimates the average complex patient bonus will be about 3 MIPS points.

Minimum Needed to Avoid a Penalty

Some key aspects of the 2018 QPP Final Rule help define possible minimal paths to avoid a MIPS penalty by achieving at least 15 MIPS points:

- Meet the ACI base score and submit 1 quality measure that meets data completeness
- Meet the ACI base score and submit 1 medium-weighted improvement activity
- Submit 2 high-weighted or 4 medium-weighted improvement activities
- Submit 6 quality measures that meet data completeness

Note that the small practice and complex patient bonuses are granted only if data is submitted for at least one of the following MIPS performance categories: Quality, IA or ACI; these bonuses will not be granted if only the cost category is scored.

Example of Calculating a MIPS Score

The 2018 QPP Final Rule contains some illustrative examples of calculating a MIPS score. In Table 34 below, the performance score in column B of 75% for quality corresponds to scoring 45 out of 60 possible points within the quality category. The category weight in column C corresponds to the quality category contributing up to 50% of the 100-point MIPS score, equivalent to up to 50 MIPS points. Hence, 75% x 50% x 100 MIPS points = 37.5 MIPS points as shown in the last column D. In this example, the practice also receives 3 complex patient bonus points, but 0 for the Small Practice Bonus.

TABLE 34: Scoring Example 2, MIPS Eligible Clinician in a Medium Practice

[A] Performance Category	[B] Performance Score	[C] Category Weight	[D] Earned Points ([B]*[C]*100)
Quality	75%	50%	37.5
Cost	50%	10%	5
Improvement Activities	40 out of 40 points 100%	15%	15
Advancing Care Information	100%	25%	25
Subtotal (Before Bonuses)			82.5
Complex Patient Bonus			3
Small Practice Bonus			0
Final Score (not to exceed 100)			85.5

2018 QPP Final Rule, Table 34, p14-815

Performance Category Re-Weighting

Under certain circumstances, such as a clinician qualifying for an exclusion from a performance category, the scoring weights among the categories will be redistributed. For instance, the ACI category may be re-weighted to 0% for clinicians claiming an EHR hardship exemption, in which case the entire 25% ACI weight is shifted to the quality category, resulting in a quality category weight of 75% rather than 50%. For a complete list of re-weighting scenarios, see Table 29 in the 2018 QPP Final Rule, p772-773.

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5. How is the Quality performance category scored?

MACRA requires that the total maximum MIPS points for the quality and cost categories sum to 60 points, or 60% of the 100-point MIPS score (excluding particular category-reweighting scenarios when clinicians are excluded from certain MIPS performance categories). The MIPS quality performance category inherits aspects of the legacy PQRS program under Medicare Part B. For example, the array of PQRS measures and reporting methods, such as qualified registry and EHR Direct, are largely preserved under MIPS. Similarly, the MIPS cost category inherits certain features of the legacy Value-Based Modifier program, such as population-based cost measures and patient attribution methodologies for calculating Medicare costs incurred by clinicians.

Quality Reporting Methods

Each MIPS-eligible clinician or group of clinicians billing Part B through a common tax identification number (TIN) may choose from these quality reporting methods (2018 QPP Final Rule, p195):

- For individual clinicians
  - Qualified Clinical Data Registry (QCDR)
  - Qualified Registry
  - EHR
  - Claims

- For groups or virtual groups
    - Qualified Clinical Data Registry (QCDR)
    - Qualified Registry
    - EHR
    - CMS Web Interface (groups of 25 clinicians or more)

For 2018, the quality performance period to be reported on is the full calendar year for all quality reporting methods.

Each reporting method requires a minimum amount of data to meet **"data completeness**":

- QCDR, qualified registry, and EHR reporting methods require at least 60% of all-payer patients or visits qualifying for the denominator of each measure to be reported.
- The claims method requires at least 60% of Medicare patients or visits.
- The CMS Web Interface method requires at least 248 Medicare patients randomly selected by CMS to be reported upon for each measure.

The CAHPS for MIPS patient satisfaction survey is an optional quality reporting method used in tandem with any of the above reporting methods designated for groups or virtual groups. If CAHPS is reported, then the group must also select one of the above reporting methods in order to meet the minimum quality data submission requirement.

The CMS Web Interface method and CAHPS for MIPS require registration with CMS by June 30, 2018 for the 2018 performance year. All other methods may be decided upon during the data submission period from January 1 to March 31, 2019, which is the first quarter following the performance year.

Quality Measures

There are approximately 300 MIPS quality measures, although typically only a subset of these are available to an organization based upon its reporting method and data sources, such as its EHR. Depending upon the reporting method, different quality measures are available and required.

- QCDR, qualified registry, EHR and claims reporting methods require at least 6 measures to be selected, with at least one an outcome measure. If an outcome measure is not available, another "high priority" measure (appropriate use, patient safety, efficiency, patient experience, or care coordination measure) can be reported.
- A clinician may choose to report a specialty measure set, defined by CMS for a particular specialty. Should a specialty measure set contain fewer than 6 measures, then a clinician could meet the minimum reporting requirement by reporting all the measures in the measure set.
- For qualified registry and claims reporting methods, a clinician may be allowed to report fewer than 6 measures by passing a validation process defined by CMS.
- For groups and virtual groups consisting of at least 16 clinicians, CMS calculates the claims-based all-cause hospital readmission (ACR) measure, and scores it if there is a minimum of 200 cases in the denominator. Note that if no quality data is submitted using the available quality reporting methods, then the ACR measure is only calculated and scored for the quality category if the clinician submits data for another MIPS category.

To explore the 2017 quality measures, see the CMS QPP website. If the QPP website has not yet been updated to show the final 2018 quality measure list, then consult Appendix Tables A – E in the 2018 QPP Final Rule (p1385 – 1597) to show new, modified and deleted measures relative to the 2017 measure list.

Quality Scoring

Within the MIPS quality category, each measure earns **"measure achievement points"**. Under a given reporting method, there is a total possible number of measure achievement points, termed the **"total available measure achievement points"**. Each measure can earn up to 10 measure achievement points. For the QCDR, qualified registry, EHR and claims reporting methods, the required 6 measures yield 60 total available measure achievement points. The **"achievement percent score"** is the total measure achievement points earned across the required number of measures divided by the total available measure achievement points. For example, if a clinician reports 6 measures using the EHR reporting method and earns 7 out of 10 measure achievement points for each measure, then the achievement percent score would be: (6 measures x 7 points) / (6*10) = 42 / 60 = 70%.

Each measure earns up to 10 measure achievement points on a peer-percentile benchmark scale based on measure performance rate (= measure numerator / denominator). Each reporting method will have a different set of measure benchmarks for the measures reported through that method. It is common for the same clinical measure to have different benchmarks for different reporting methods. The baseline period for deriving benchmarks is generally two years prior to the performance year.

For example, if a PQRS measure has a 62% measure performance rate that is better than 60% of peers reflected in the benchmark, then that measure would earn 7.0 out of 10 possible points, according to this illustrative measure benchmark table:

Example of Quality Benchmarks for a Single Measure to Assign Measure Achievement Points

Decile	Measure Performance Rate	Range of Measure Achievement Points
Decile 1	0 – 6.9%	3.0
Decile 2	7.0 – 15.9%	3.0
Decile 3	16.0 – 22.9%	3.0 – 3.9
Decile 4	23.0 – 35.9%	4.0 – 4.9
Decile 5	36.0 – 40.9%	5.0 – 5.9
Decile 6	41.0 – 61.9%	6.0 – 6.9
Decile 7	62.0 – 68.9%	7.0 – 7.9
Decile 8	69.0 – 78.9%	8.0 – 8.9
Decile 9	79.0 – 84.9%	9.0 – 9.9
Decile 10	85.0 – 100%	10

If a measure rate lies within a benchmark decile rather than on a decile boundary, then one would linearly-interpolate the quality point value between the decile boundaries to derive the quality points to the nearest tenth of a point. For performance year 2018, note that there is a 3-point floor for scored measures meeting data completeness and case minimum requirements, as reflected in the above example table.

Bonus points can be earned in the quality category by reporting multiple high priority measures, reporting Quality data using End-to-End reporting or by showing improvement from the prior performance year.

High Priority Measure Bonus Points:

- ”High priority measure bonus points” are added to the measure achievement points when an additional high priority measure is reported beyond the required outcome measure or other high priority measure. Outcome or patient experience measures earn 2 points, and other high priority measures earn 1 point.
- There is a cap on the total accumulated high priority measure bonus points of up to 10% of the total available measure achievement points. With 60 measure achievement points available, the high priority measure bonus cap is 6 points.
- There is also a bonus of 1 point for each quality measure submitted with end-to-end electronic reporting (such as via the EHR method), up to a category-wide bonus cap of 10% of the total available measure achievement points.

Improvement Percent Score:

- Additional points can be earned for improvement in the quality category achievement percent score from the prior performance year.
- **“Improvement percent score”** (up to a 10% cap) = 10% x (increase in achievement percent score from prior performance year) /(prior performance year achievement percent score)
- The 10% cap is reached when the performance year’s achievement percent score is double that of the prior performance year.
- A floor of 30% is applied to the denominator in the above formula to avoid unduly rewarding clinicians who score lower than 30% in the 2017 quality category due to reporting minimal data.

The total quality performance category percent score is then calculated from the above three components (total measure achievement points, total measure bonus points, improvement percent score):

“Quality performance category percent score” = [(total measure achievement points + total measure bonus points) / (total available measure achievement points)] + improvement percent score

For example, assume a clinician reports 6 measures using the EHR reporting method and earns:

- 7 out of 10 measure achievement points for each measure,
- 4 bonus points for reporting 2 additional outcome measures,
- 2 bonus points for submitting two measures via end-to-end electronic reporting, and
- a 5% improvement percent score.

The quality performance category percent score would be: (6*7 + 4 + 2) / (6*10) + 5% = 48 / 60 + 5% = 85%

If the category percent score were to exceed 100%, then it would be capped at 100%.

The formula to translate the quality performance category percent score into a MIPS score contribution is:

Quality category MIPS points =
(quality performance category percent score) x (quality category weight) x 100 MIPS points

If no category re-weighting occurs such that the quality category weight is 50%, then extending the above example yields: quality category MIPS points = 85% x 50% x 100 = 42.5 MIPS points. Each tenth of a MIPS point impacts the payment adjustment.

Conditions Limiting the Measure Achievement Points

For the 2018 performance year, any of the below conditions may reduce the number of measure achievement points below what a quality measure would earn based upon its performance rate:

1. **Not reporting for the full performance year:** assigned 0 out of 10 measure achievement points
2. **Not meeting data completeness:** if in a small practice with 15 clinicians or fewer, assigned 3 points; otherwise, assigned 1 point
3. **Not meeting the measure's case minimum (e.g., a denominator of 20):** assigned 3 points
4. **No measure benchmark exists:** assigned 3 points
5. **Measure is topped-out and thereby subject to special scoring**: capped at 7 points; "topped-out" means that the national median performance rate is so high as to limit the utility of the measure in meaningfully differentiating performance between clinicians, e.g. a process measure with a national median performance rate of 95% or higher.

There are 6 topped-out measures identified by CMS for the 2018 performance year (2018 QPP Final Rule, Table 18, p554-555). However, based on 2015 historic data, CMS estimates that about 45% of quality measure benchmarks are topped out, including 70% of claims measures, 10% of EHR measures, and 45% of QCDR and qualified registry measures (2018 QPP Final Rule, Table 18, p548). Hence, CMS anticipates for the 2019 performance year that many more measures will be subject to the 7-point special scoring cap for topped-out measures, impacting an organization's ability to maintain high MIPS scores above the performance threshold, or to capture exceptional performance incentives.

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6. How is the Cost performance category scored?

Cost for the 2018 Performance Year

For the 2018 performance year, the MIPS cost category is weighted at 10% and therefore worth up to 10 MIPS points. Cost measures are calculated using claims, and are inherited with minimal modifications from the Value-Based Modifier program: the total per capita (TPC) cost measure and the Medicare Spending Per Beneficiary (MSPB) cost measure.

- The TPC measure calculates the average per-patient Medicare Part A and Part B allowed charges (cost to Medicare plus co-pay and co-insurance charges to patients) for patients attributed to a clinician or group of clinicians (identified by tax identification number or TIN). Attribution of a given patient is based upon which clinician or group, respectively, billed the most allowed charges for primary care services delivered to that patient.
- The MSPB measure calculates the average per-hospitalization-admission Medicare Part A and Part B costs to Medicare (excludes patient co-pay and co-insurance charges) for hospitalization episodes attributed to a clinician or group of clinicians. Attribution of an episode is based upon

which clinician or group, respectively, billed the most allowed charges for physician services delivered to the patient during the hospitalization.

Cost Scoring

The cost measures are scored in a manner similar to the quality measures, where each measure earns up to 10 measure achievement points via a peer-percentile benchmark scale based on measure performance rate. Hence, the total available measure achievement points are equal to 2 measures x 10 points = 20 points. Unlike the quality category, there is no elevated 3-point floor on the measure achievement points, and there are no measure bonus points.

"Cost performance category percent score" = (total measure achievement points) / (total available measure achievement points)

For example, assume a clinician is scored on both cost measures and earns:

- 7 out of 10 measure achievement points for the Cost Per Capita measure,
- 5 out of 10 measure achievement points for the MSPB measure, and

The cost performance category percent score would be: (7 + 5) / (2*10) = 12 / 20 = 60%.

The formula to translate the cost performance category percent score into a MIPS score contribution is:

Cost category MIPS points =
(cost performance category percent score) x (cost category weight) x 100 MIPS points

If no category re-weighting occurs such that the cost category weight is 10%, then extending the above example yields: cost category MIPS points = 60% x 10% x 100 = 6.0 MIPS points.

Cost for the 2018+ Performance Years

Per the MACRA legislation, the combined weight of the Quality and Cost categories must equal 60% of the overall MIPS score. In 2018, the category weights will be 50% and 10%, respectively. Due to modifications made by the Bipartisan Budget Act of 2018, CMS does not have to move the Cost category weight to 30% until 2022. However, during the years 2019-2021, CMS may choose any Cost category weight between 10% to 30%, with the Quality category weight reduced by that increase such that both category weights always add up to 60%. In addition, MACRA requires that CMS develop new episode-based cost measures which account for a target of at least ½ of all national Medicare expenditures under Part A and Part B. CMS has spent several years iteratively developing and testing candidate measures, and the 2018 QPP Final Rule confirms that eight new episode-based measures will be calculated and scored beginning with the 2019 performance year. CMS has released field-testing feedback reports to clinicians and groups who meet the case minimum for each measure. CMS will publish additional performance feedback on these new measures in the summer of 2018 as part of the first MIPS feedback report.

We discuss below some ways to prepare for the MIPS cost category going forward.

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7. How are the Advancing Care Information (ACI) and Improvement Activities (IA) performance categories scored?

Advancing Care Information (ACI)

The MIPS ACI category inherits and scores measures from Modified Stage 2 Meaningful Use (MU) and Stage 3 MU in order to gauge the level and maturity of EHR usage. These two sets of ACI measures are termed the “ACI transition measure set” (Modified Stage 2) and “ACI measure set” (Stage 3), respectively. For the 2018 performance year, a clinician may choose which set of measures to report and may do so using any combination of 2014 or 2015 Edition Certified EHR Technology (CEHRT) supporting such measures. The minimum performance period is a 90-days within the performance year for all reported measures.

A clinician earns ACI measure points as the sum of three components:

- **Base Score:** 50 measure points for reporting either a non-zero numerator or a “yes,” as applicable, for designated measures from the ACI transition measure set or ACI measure set; all measures must be met for the measure set chosen by the clinician, otherwise the entire ACI category is assigned a zero;
- **Performance Score:** Up to 90 points for designated measures from the chosen measure set, where each measure is worth up to either 10 or 20 measure points; performance rates are scored on a static decile scoring scale (not peer benchmarked) where, for instance, a performance rate of 50% earns 5 points out of 10, 60% earns 6 points out of 10 and so on;
- **Bonus Points:** Up to 15 or 25 total bonus points can be earned for the chosen measure set.

For a list of measures and available points within the ACI measure set and the ACI transition measure set, including bonus points, see Tables 7 and 8, respectively, in the 2018 QPP Final Rule on p393 - 394.

ACI Scoring

The total earned measure points are divided by 100 total available measure points to derive an ACI performance category percent score. If the percent score is greater than 100%, then it is capped at 100%.

The formula to translate the ACI performance category percent score into a MIPS score contribution is:

ACI category MIPS points = (ACI performance category percent score) x (ACI category weight) x 100 MIPS points.

If the base score = 50 points, performance score = 40 points, bonus points = 5, and ACI category weight = 25%, then: ACI category MIPS points = (50 + 40 + 5)/100 x 25% x 100 = 23.75 MIPS points.

Note that some MIPS-eligible clinicians such as hospital-based clinicians who were previously ineligible for ambulatory MU are excluded from the ACI category. In addition, clinicians may be granted hardship exemptions from ACI through an annual application process. For such clinicians, the ACI category weight is set to 0% and shifted towards other performance categories per the MIPS re-weighting rules.

Improvement Activities (IA)

The MIPS IA category gauges the extent to which a clinician or group of clinicians is engaged in activities to improve clinical practice or care delivery. Clinicians earn points by attesting the minimum 90-day performance period within the performance year for each reported activity; each activity may have a different 90-day period.

To explore the 2017 improvement activities, see the CMS QPP website. If the QPP website has not yet been updated to show the final 2018 activity list, then consult Appendix Tables F and G in the 2018 QPP Final Rule (p1598 – 1653) (link did not work) to show new and modified activities relative to the 2017 list.

Here are the ways to earn the maximum possible IA score:

- Clinicians in small practices (15 or fewer clinicians), practices located in rural areas or geographic HPSAs, or non-patient facing clinicians must earn at least 20 activity points, whereas
- all other clinicians or clinician groups must earn at least 40 activity points to earn the maximum possible IA score.

The "**IA performance category percent score"** is calculated by dividing the total earned activity points by either 20 or 40 points, respectively. If the percent score is greater than 100%, then it is capped at 100%.

Clinicians earn activity points in the following ways:

- Report any combination of medium-weight (10 points each) and/or high-weight activities (20 points each), or
- if a clinician participates in an APM such as the Medicare Shared Savings Program or the Oncology Care Model, then the clinician automatically earns 20 points or 40 points, as determined by CMS for the APM, or
- if a clinician is in a certified patient-centered medical home or comparable specialty practice, then the clinician automatically earns 40 points.

IA Scoring

The formula to translate the IA performance category percent score into a MIPS score contribution is:

IA category MIPS points = (IA performance category percent score) x (IA category weight) x 100 MIPS points. If the total earned activity points = 30 points, activity points needed for max IA score = 40 points, and IA category weight = 15%, then: IA category MIPS points = (30/40) x 15% x 100 = 11.25 MIPS points.

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8. What are MIPS data submission and audit requirements?

Data Submission

As discussed above for MIPS data submission and scoring, an organization may choose to report data for clinicians individually or as a group that bills through a common tax identification number (TIN). The choice

is made consistently across all MIPS performance categories for either a clinician or a group for a given performance year. The choice may be changed annually.

Inclusive of the reporting methods for the quality category, the following is CMS' summary table of reporting methods (or data submission mechanisms) by MIPS performance category:

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups (Including Virtual Groups)
Quality	QCDR Qualified Registry EHR Claims	QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
Improvement Activities	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Advancing Care Information	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)

CMS Webinar: "Final Rule with Comment Period for QPP Year 2 (2018)", p30

For the 2018 performance year, the quality, improvement activities and advancing care information categories must each be submitted using one reporting method for a given clinician or group. However, each such category may be reported using a different method. The 2018 QPP Final rule states that beginning with the 2019 performance year, each category may be reported using multiple reporting methods, each for a subset of the measures being reported for that category. By being able to mix-and-match reporting methods and measures within one category, clinicians will have a greater effective choice of measures to report for a given performance year.

Due date - For MIPS, clinician performance data for the Advancing Care Information, Quality, and Improvement Activities categories for a performance year are generally due to CMS by March 31st of the following calendar year.

For a clinicians participating in a MIPS APM, see our APM FAQs to learn about special rules governing MIPS data submission. For example, the MIPS quality category will not require a separate data submission if CMS is already collecting quality data for the APM.

Audit Requirements

MIPS is auditable by CMS for up to 6 years after the associated data submission. Annually, CMS will selectively audit clinicians and groups and require them to share primary source documents, such as patient medical records, within 45 days of request (2018 QPP Final Rule, p837-839). CMS has published recommended data validation and audit documentation for all 2017 MIPS categories and measures. (LINK did not work) Check the CMS QPP resource library website for updates related to the new and modified activities for 2018.

Some further guidance for different MIPS performance categories:

- **Quality** – Past precedence with CMS PQRS audits indicates that it is important to retain archived EHR patient-level snapshots of the entire period of data reported upon. In addition, certain 3rd-party data submission entities such as qualified registries and QCDRs are subject to annual CMS audit requirements which may involve the clinicians and groups they serve.
- **Cost** – No separate auditing requirements apart from the usual auditability of the administrative claims upon which the cost measures are based.
- **Advancing Care Information** – Likely to be audited in the manner that Meaningful Use (MU) was audited in the past. Pay special attention to retaining documents supporting the annual IT security risk assessment applicable to the reporting period, as this was a common audit vulnerability under MU.

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9. How is MIPS different in 2018 versus 2017, and how will it further change in 2019?

The 2018 QPP Final Rule confirms that CMS is generally increasing the rigor of the MIPS program in the 2018 performance year, with increased competition and complexity each year beyond 2018 until 2022 when the transition period concludes.

2018 Versus 2017

The CMS Fact Sheet for the 2018 QPP Final Rule contains a table comparing the 2018 MIPS rules to those of 2017, some of which we have covered elsewhere in these FAQs. Key changes include:

- MIPS performance threshold raised from 3 points to 15 points out of 100
- MIPS cost category weight increased from 0% to 10%, and quality down from 60% to 50%
- Introduction of virtual groups as a new way to group clinicians for reporting MIPS
- Raising the low-volume MIPS exclusion threshold, which causes an estimated 80% of MIPS eligible clinicians to be in organizations of greater than 25 clinicians each for 2018
- Minimum quality reporting period expanded from 90-days to the full calendar year
- Data completeness threshold for most quality reporting methods increased from 50% to 60%
- New 10% ACI category bonus for exclusively using 2015 Edition CEHRT
- New deadline of December 31st of the performance year to apply for an ACI hardship exemption
- Exclusions for the ACI e-Prescribing and Health Information Exchange base measures, effective for both 2017 (retro-active) and 2018
- MIPS bonus points for complex patients and small practices
- Category Improvement Scores for Quality Category

Further Changes for 2019

Towards increasing the robustness of the MIPS program, the bi-partisan MACRA legislation and the 2018 QPP Final Rule, as indicated, require the following to occur for the 2019 performance year:

- Likely increase in the MIPS performance threshold due to the mandate of the Bipartisan Budget Act of 2018 to gradually increase the threshold each year through becoming equal to the national historical mean or median of MIPS scores in the 2022 performance year; CMS predicts that 74% of 2018 MIPS scores earned by clinicians and groups will be over 70 out of 100 MIPS points.
- Multiple reporting methods allowed for the same MIPS performance category and the same clinician or clinician group for a given performance year (2018 QPP Final Rule)
- More quality measures subject to 7-point cap for being topped-out measures
- Introduction of facility-based MIPS scoring for quality and cost which, for example, hospital-based clinicians can have the option to choose
- Introduction of new episode-based measures in the Cost category

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10. How does an organization sustainably succeed on the MIPS path?

For clinicians and groups committed to succeeding on the MIPS path, there must be a leadership and organization-wide commitment to continuous performance improvement. Increased competition among clinicians to achieve high MIPS scores as measure benchmarks and score thresholds rise will continue to raise the financial and reputational stakes. Furthermore, measure-level benchmarks will continue to rise in difficulty and the introduction of point caps for topped-out measures in the MIPS quality category will put downward pressure on MIPS scores.

Overall, given the typical long lead times to materially improve quality and cost performance, leading provider organizations are formulating multi-year MIPS success plans, including key activities and decisions such as these:

- Educating leaders about the evolution of MIPS over the next 2 years
- Estimating current MIPS baseline performance ahead of the 2017 MIPS feedback report (released by CMS in fall 2018)
- Identifying organizational gaps versus status quo in light of continued changes to MIPS
- Gaining early insight into MIPS cost category performance and improvement levers through analyzing existing data sources, such as CMS QRUR reports and internal claims data
- At least annually re-visiting past MIPS program decisions, such as individual-clinician versus group reporting or the choice of quality data submission method, to account for program and organizational changes
- Strengthening or establishing a continuous performance improvement discipline and process perhaps catalyzed by MIPS, but extensible to other value-based programs as well
- Re-evaluating how resources are allocated and the structure of the organization in response to the need to optimize MIPS
- Creating a multi-year QPP roadmap, including MIPS and APMs, based on qualitative and quantitative factors of importance to the organizations, such as clinician engagement, revenues, public reputation, and quality improvement

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CMS References

CMS QPP website

CMS QPP Resource Library website (also linked to by the CMS QPP website)

2018 QPP Final Rule in the Federal Register

2018 QPP Final Rule – public inspection version (generally easier to read and annotate this PDF)

CMS 2018 QPP Executive Summary

CMS 2018 QPP Fact Sheet (detailed table about how 2018 QPP and MIPS compares to 2017)

CMS Webinar (November 30, 2017): "Final Rule with Comment Period for QPP Year 2 (2018)"