The Physicians Advocacy Institute’s Medicare Quality Payment Program (QPP) Physician Education Initiative

2017 Merit-Based Incentive Payment System (MIPS) Scoring Overview
What is MIPS?

Under MACRA’s Quality Payment Program (QPP), physicians may choose to participate in an Advanced Alternative Payment Model (APM) or submit data to the Merit-Based Incentive Payment System (MIPS).

MIPS is a new program that consolidates and sunsets the previous quality reporting programs, including the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Electronic Health Records (EHR) Incentive program (Meaningful Use), into one program. In 2017, MIPS has four weighted performance categories: quality (60%), based on PQRS; cost (0%), based on VM; advancing care information (25%), based on Meaningful Use; and improvement activities (15%), new category not based on a previous program.

How is performance measured under MIPS?

Physicians’ MIPS scores are determined on their overall performance in each of the four MIPS categories compared to the CMS performance threshold score for a given year. Physicians will receive a score in each category, and their MIPS final score will be the sum of the weighted score of each category.

Note: there is a two-year gap between the performance year and the payment adjustment year. Therefore, 2017 MIPS performance will be used to assess the 2019 payment adjustment.

1 Please note that this scoring overview is only for the 2017 MIPS participation year. The specific scoring and points will be different in 2018.
What are the MIPS performance categories?

The four MIPS categories are: 1) quality (building off PQRS); 2) advancing care information (ACI) (building off Meaningful Use); 3) cost (building off the VM); and 4) improvement activities (a new category that rewards engagement in clinical quality improvement activities).

How is the performance threshold determined?

CMS will publish a minimum threshold of points out of 100 that physicians must achieve in their MIPS final score to avoid a negative payment adjustment. For 2017, the threshold for avoiding a negative payment adjustment is only 3 out of 100 total points – this can be achieved by reporting at least 1 quality measure or improvement activity. For 2018, the minimum threshold to avoid a penalty will be proposed in CMS rulemaking in the summer of 2017 and finalized in the fall of 2017. For 2019 and beyond, CMS will make threshold determinations using mean or median final scores from a prior performance period.

What are the weights of each category?

Since 2017 serves as a transition year for the MIPS program, the cost category is reweighted to 0% of the MIPS final score for 2017 performance; the quality category is 60% of the final score; the improvement activities category is 15% of the final score; and the ACI category is 25% of the final score.

How will CMS calculate your MIPS performance score in 2017?

For the 2017 transition year, CMS set the performance threshold at 3 points. If the final score is below the threshold, physicians will receive a negative payment adjustment of their Medicare Part
B payments in 2019; if the final score is equal to the threshold, physicians will receive a neutral adjustment of their Medicare Part B payments; and if the final score is above the threshold, physicians will receive a positive adjustment of their Medicare Part B payments. Additionally, physicians whose performance meets or exceeds a final score of 70 points, will be eligible for an additional positive payment adjustment of their Medicare Part B payments for exceptional performance, funded from a pool of $500 million.

The infographics below summarize the formula of how the overall MIPS performance score will be calculated in 2017.

\[
\text{(Quality score \times 60\%)(100) + (Improvement Activities score \times 15\%)(100) + (ACI score \times 25\%)(100) = 2017 MIPS final score}
\]

To avoid a negative payment adjustment, the 2017 MIPS final score must be \( \geq 3 \)

**MIPS Case Study Example**

Dr. Jane Doe operates an independent family medicine practice and has decided to participate in MIPS for the 2017 performance year. Dr. Doe submits data for each of the three scored categories for 2017 through a qualified clinical data registry (QCDR). Her quality category score is 58%, improvement activities category score is 100%, and ACI category score is 68%. Her 2017 MIPS final score will be calculated as follows:

\[
\text{Quality (.58\times .60)(100) + Improvement Activities (1 \times .15)(100) + ACI (.68 \times .25)(100) = 66.8 MIPS Final Score}
\]

Because her final score is 66.8 points, and above the 3-point threshold for 2017, Dr. Doe will receive a positive payment adjustment of her 2019 Medicare Part B FFS claims. However, because her score falls below the 70-point threshold for exceptional bonus, Dr. Doe will not be eligible for an additional positive payment adjustment for exceptional performance.
How are the scores for each category calculated?

**Quality Category**

There are two parts to the quality category score: 1) the points received for each reported measure, and 2) bonus points.

**Individual and Group Reporting**

Under the individual and group reporting options, physicians receive 3-10 points for each measure based on their performance compared to a benchmark. Physicians will automatically receive 3 points for submitting appropriate data for a measure. More points will be received with high performance compared to the benchmark for the measure. Benchmarks for each measure are specific to the type of reporting mechanism (EHR, registry, QCDR, consumer assessment of healthcare providers and systems (CAHPS) survey, or claims) being utilized for reporting data for the quality category.

For 2017, the benchmark for each measure is presented in terms of 8 deciles. Each decile is associated with a performance range, and the number of points that a physician will receive for any measure will depend on their exact position in the decile. For example, for a given measure, if a physician submits data showing 66% performance on a measure, and for that measure the 66% performance falls in the range for decile 7, then the physician would receive 7.0-7.9 points for that measure. The table below depicts the number of points that are achievable for each decile.
## Decile Points Assigned for 2017 MIPS Performance

<table>
<thead>
<tr>
<th>Decile</th>
<th>Points Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 3</td>
<td>3 points</td>
</tr>
<tr>
<td>Decile 3</td>
<td>3.0-3.9 points</td>
</tr>
<tr>
<td>Decile 4</td>
<td>4.0-4.9 points</td>
</tr>
<tr>
<td>Decile 5</td>
<td>5.0-5.9 points</td>
</tr>
<tr>
<td>Decile 6</td>
<td>6.0-6.9 points</td>
</tr>
<tr>
<td>Decile 7</td>
<td>7.0-7.9 points</td>
</tr>
<tr>
<td>Decile 8</td>
<td>8.0-8.9 points</td>
</tr>
<tr>
<td>Decile 9</td>
<td>9.0-9.9 points</td>
</tr>
<tr>
<td>Decile 10</td>
<td>10 points</td>
</tr>
</tbody>
</table>

To determine the performance ranges for the specific measure(s) you are reporting, please download the 2017 Quality Benchmarks file available on CMS’s QPP website at: [https://qpp.cms.gov/resources/education](https://qpp.cms.gov/resources/education). The CMS file details the benchmark deciles and performance ranges for all measures and for all available reporting mechanisms. For quality measures that are reportable through more than one reporting mechanism, note that benchmarks vary and selecting one method over another can impact your performance score.

Physicians can also earn bonus points for reporting additional high-priority measures (not included in denominator for total points), or reporting measures electronically using an EHR, registry, or QCDR. Bonus points are subject to a cap for the quality and ACI categories.

<table>
<thead>
<tr>
<th>Bonus Points Activity</th>
<th>Bonus Points Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitting an additional outcome or patient experience measure</td>
<td>2 bonus points for each additional measure</td>
</tr>
<tr>
<td>Submitting an additional high-priority measure</td>
<td>1 bonus point for each additional measure</td>
</tr>
<tr>
<td>Submitting measures electronically</td>
<td>1 bonus point for each measure submitted electronically end-to-end</td>
</tr>
</tbody>
</table>

The score for the quality category is then determined by taking the total number of points received for all reported measures, adding any bonus points that were received, and then dividing the total number of points received by the maximum number of points that could have been achieved (maximum points = 10 x number of measures reported).
For groups of 16 or more eligible clinicians, and with > 200 cases that meet the all-cause readmission measure, this measure will automatically be calculated using administrative claims data and would be counted in addition to the individual measures reporting requirement.

A similar approach is taken for groups of 25 or more eligible clinicians who elect to report data for the quality category using the CMS Web Interface. Groups who participate using the CMS Web Interface agree to report on all 15 Web Interface measures. However, only 11 of those measures have benchmarks and will be counted as part of the total score. In this case, the group will receive 3-10 points based on its performance and the decile that performance falls into for each CMS Web Interface measure.

Additionally, the all-cause readmission measure will automatically be calculated using administrative claims data if the 200 cases threshold is met or exceeded, and this measure would be counted in addition to the 11 scored measures. Groups would also have the opportunity to earn bonus points for reporting additional high-priority measures (not included in denominator for total points); or reporting measures electronically using an EHR, registry, or QCDR.

The score for the quality category will be calculated the same way, by taking the total number of points received for all reported measures, adding any bonus points that were received, and then dividing the total number of points received by the maximum number of points that could have been achieved (maximum points = 10 x number of measures reported).
ACI Category

The ACI category score has three components: 1) points for reporting base score measures; 2) measure performance score points; and 3) bonus points.

ACI Category Score

Physicians receive their base score, worth 50 points, by reporting yes / no or numerator / denominator for all required base score measures (either 4 or 5 measures, the exact number of base score measures depends on use of 2014 or 2015 certified electronic health record technology (CEHRT)). The base score measures must be reported to receive any credit for the ACI category; failure to report the base score measures will result in a 0% score for the ACI category.

Physicians can also report up to 9 optional measures for additional performance score of up to 90 points. Each additional performance score measure is worth up to 10 or up to 20 points depending on the performance rate for the measure. The following chart demonstrates what this would look like for a performance score measure worth up to 10 points.
### Performance Rate

<table>
<thead>
<tr>
<th>Performance Rate</th>
<th>Points Assigned for 2017 MIPS Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% - 10%</td>
<td>1</td>
</tr>
<tr>
<td>11% - 20%</td>
<td>2</td>
</tr>
<tr>
<td>21% - 30%</td>
<td>3</td>
</tr>
<tr>
<td>31% - 40%</td>
<td>4</td>
</tr>
<tr>
<td>41% - 50%</td>
<td>5</td>
</tr>
<tr>
<td>51% - 60%</td>
<td>6</td>
</tr>
<tr>
<td>61% - 70%</td>
<td>7</td>
</tr>
<tr>
<td>71% - 80%</td>
<td>8</td>
</tr>
<tr>
<td>81% - 90%</td>
<td>9</td>
</tr>
<tr>
<td>91% - 100%</td>
<td>10</td>
</tr>
</tbody>
</table>

### Additional bonus points

(up to a total of 15 points) can be achieved for reporting a public health/clinical data registry measure, and by using CEHRT for activities in the Improvement Activities category.

<table>
<thead>
<tr>
<th>Bonus Points Activity</th>
<th>Bonus Points Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting a public health/clinical data registry measure</td>
<td>5 bonus points</td>
</tr>
<tr>
<td>Using CEHRT to report an improvement activities (can select from 18 activities)</td>
<td>10 bonus points</td>
</tr>
</tbody>
</table>

While the maximum number of points you may achieve for the ACI category can be over 100, the maximum score you can achieve for the ACI category is 100%.
**Improvement Activities Category Scoring**

The improvement activities category score only has one component: points earned for completing one or more improvement activity. Unlike the quality and ACI categories, the improvement activities category does not have an opportunity for physicians to earn bonus points.

Physicians can complete any combination of high weight activities (worth 20 points each) and medium weight activities (worth 10 points each) during a 90-day reporting period equaling at least 40 total points, including the following combinations:

- 2 high-weight activities (2 x 20 = 40 points)
- 4 medium-weight activities (4 x 10 = 40 points)
- 2 medium-weight activities AND 1 high-weight activity ((2 x 10) + (1 x 20) = 40 points)

The number of points associated with high and medium weight activities is increased for solo practitioners, groups of 15 or fewer, rural area, health professional shortage area (HPSA), and non-patient facing practice physicians. These physicians can also complete any combination of high weight activities (worth 40 points each) and medium weight activities (worth 20 points each) during a 90-day reporting period equaling at least 40 total points, including the following combinations:

- 2 medium-weight activities (2 x 20 = 40 points)
- 1 high-weight activity (1 x 40 = 40 points)
In addition, using CEHRT to report a clinical practice improvement activity can earn physicians bonus points towards the Advancing Care Information category score.

Cost Category Scoring

For the cost category, physicians will not be required to submit data on specific cost measures. CMS will use administrative claims data to measure performance. Although the cost category will not be scored for 2017, CMS will provide feedback on performance using administrative claims data, but it will not affect your 2017 performance score for the 2019 payment adjustment.

CMS finalized 10 episode-based measures, along with the total per capita cost measure and the Medicare Spending Per Beneficiary measure for the cost performance category. Performance on these measures was previously assessed under the Medicare Value-Based Payment Modifier program, but will include modifications to the attribution methodology under MIPS. CMS is also developing new patient condition groups and patient relationship codes (episode groups). The measures and scoring details are still being developed for this category, but it is expected that the cost category score will be calculated by taking the total number of points earned and dividing it by the total number of points available.

Note: the cost category will be scored beginning in 2018, and will be 10% of your 2018 MIPS final score, and 30% of your MIPS final score for 2019 and beyond. The quality category weight will be readjusted in response, and will be 50% of your 2018 MIPS final score, and 30% of your MIPS final score for 2019 and beyond.
MIPS Category Weights for 2018 and Beyond

**2018 - Category Weights**
- Quality: 50%
- Improvement Activities: 15%
- ACI: 25%
- Cost: 10%

**2019 and Beyond - Category Weights**
- Quality: 30%
- Improvement Activities: 15%
- ACI: 25%
- Cost: 30%
Where can I go for more information?
To learn more about each of the MIPS category reporting requirements, please see the resources available on the PAI’s website. Additional resources are available on CMS’s QPP website at: https://qpp.cms.gov.