The Medicare Access & Chip Reauthorization Act of 2015

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM:

MIPS Scoring Methodology Overview

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians

IF

Overall physician costs

>

Target Medicare expenditures

Physician payments cut across the board

Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

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

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

FOCUSING ON THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MIPS: First Step to a Fresh Start

- ✓ **MIPS is a new program**
  - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
  - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**

Quality

Resource use

Clinical practice improvement activities

Advancing care information

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Who Will Participate in MIPS?

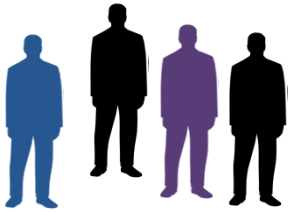
Affected clinicians are called **"MIPS eligible clinicians"** and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians, PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

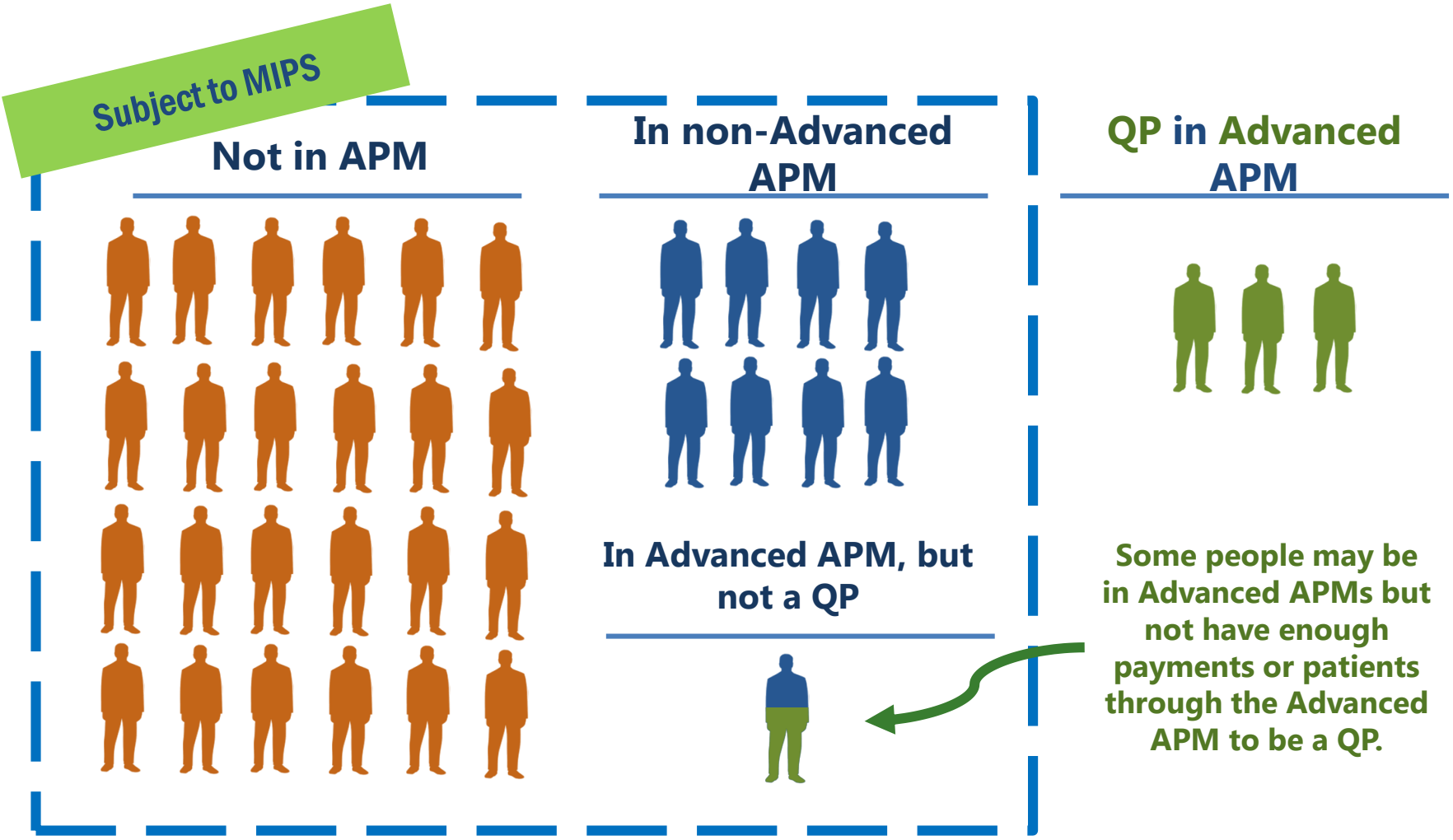
Secretary may broaden Eligible Clinicians group to include others such as



Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Note: Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

Note: Most clinicians will be subject to MIPS.



Note: Figure not to scale.

PROPOSED RULE

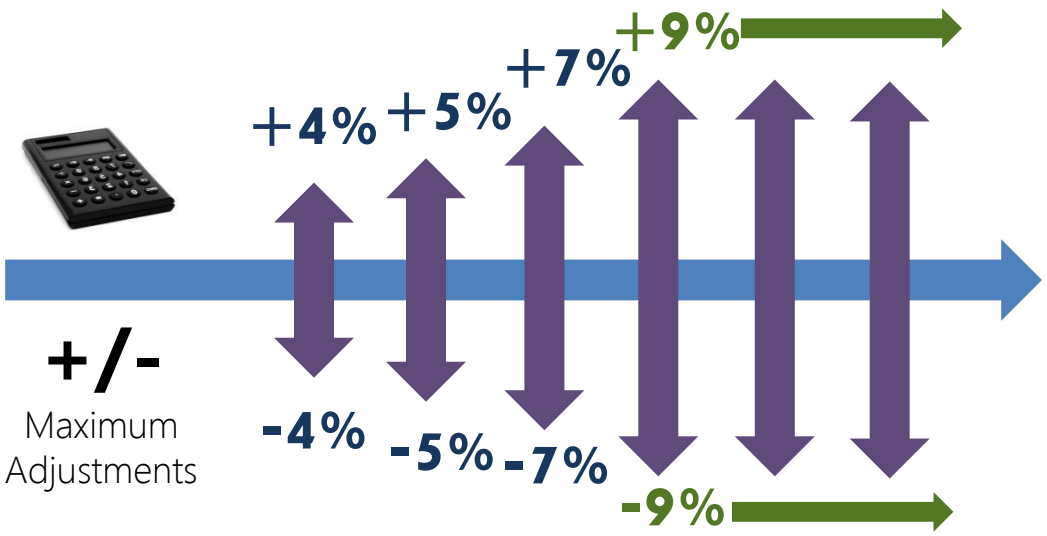
MIPS Timeline

2017	2018	July		2019	2020
Performance Period (Jan-Dec) 1st Feedback Report (July)	Reporting and Data Collection	2nd Feedback Report (July)	Targeted Review Based on 2017 MIPS Performance	MIPS Begins to Pay for Quality	

Analysis and Scoring

How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score , clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.



Adjusted Medicare Part B **payment** to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

PROPOSED RULE
MIPS: PERFORMANCE CATEGORIES & SCORING

MIPS Performance Categories

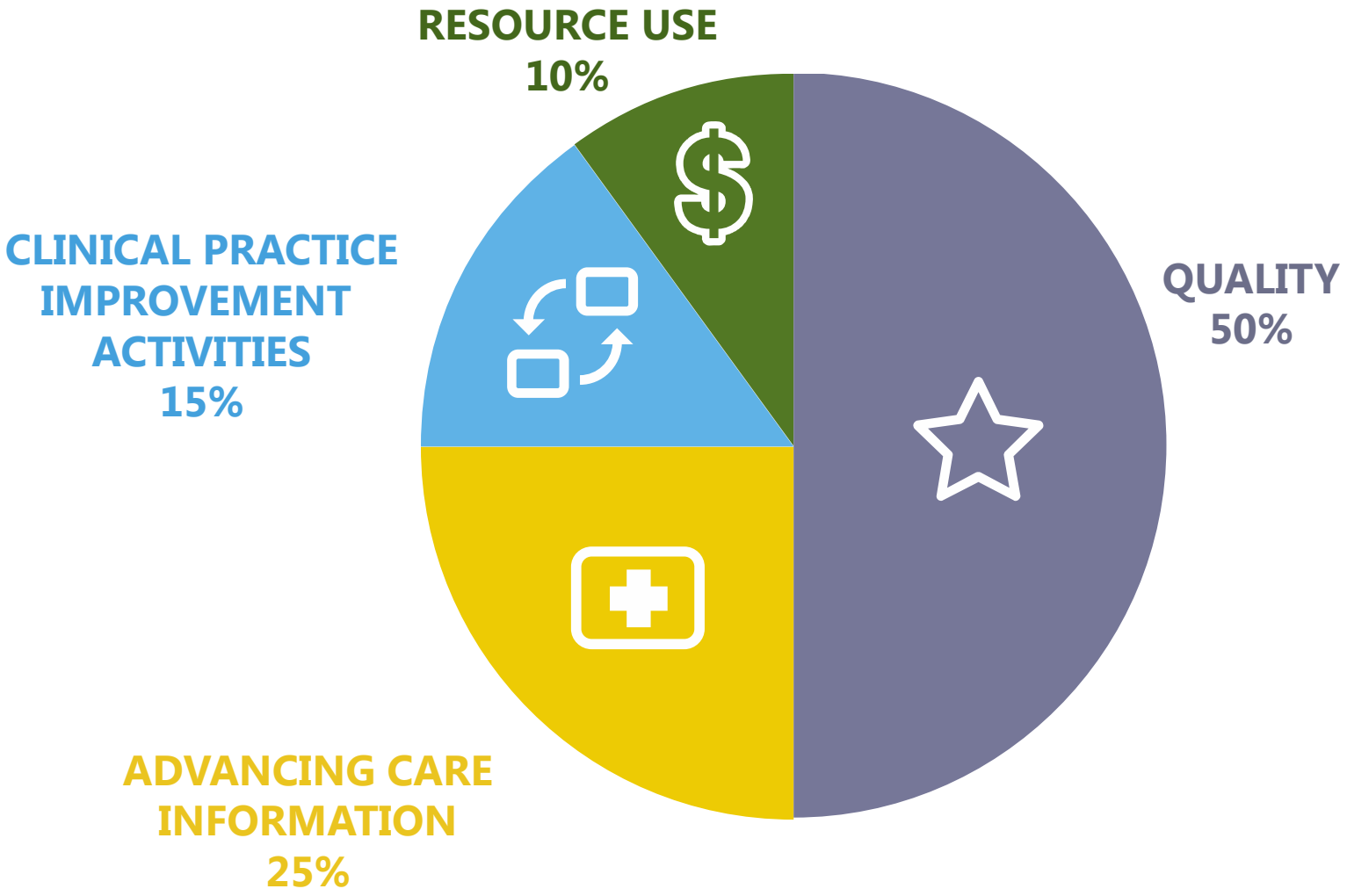
A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:

PROPOSED RULE

MIPS: Performance Category Scoring

Summary of MIPS Performance Categories			
	Performance Category	**Maximum Possible Points per Performance Category**	**Percentage of Overall MIPS Score (Performance Year 1 - 2017)**
	**Quality:** Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-priority measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
	**Advancing Care Information:** Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
	**Clinical Practice Improvement Activities:** Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn "full credit" in this category, and those participating in APMs will earn at least half credit.	60 points	15 percent
	**Resource Use:** CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all resource use measures that can be attributed	10 percent

2019 Performance Category Weights for MIPS



PROPOSED RULE

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

- ✓ **MIPS composite performance scoring method that accounts for:**
  - **Weights of each performance category**
  - **Exceptional performance factors**
  - **Availability and applicability of measures for different categories of clinicians**
  - **Group performance**
  - **The special circumstances of small practices, practices located in rural areas, and non-patient- facing MIPS eligible clinicians**

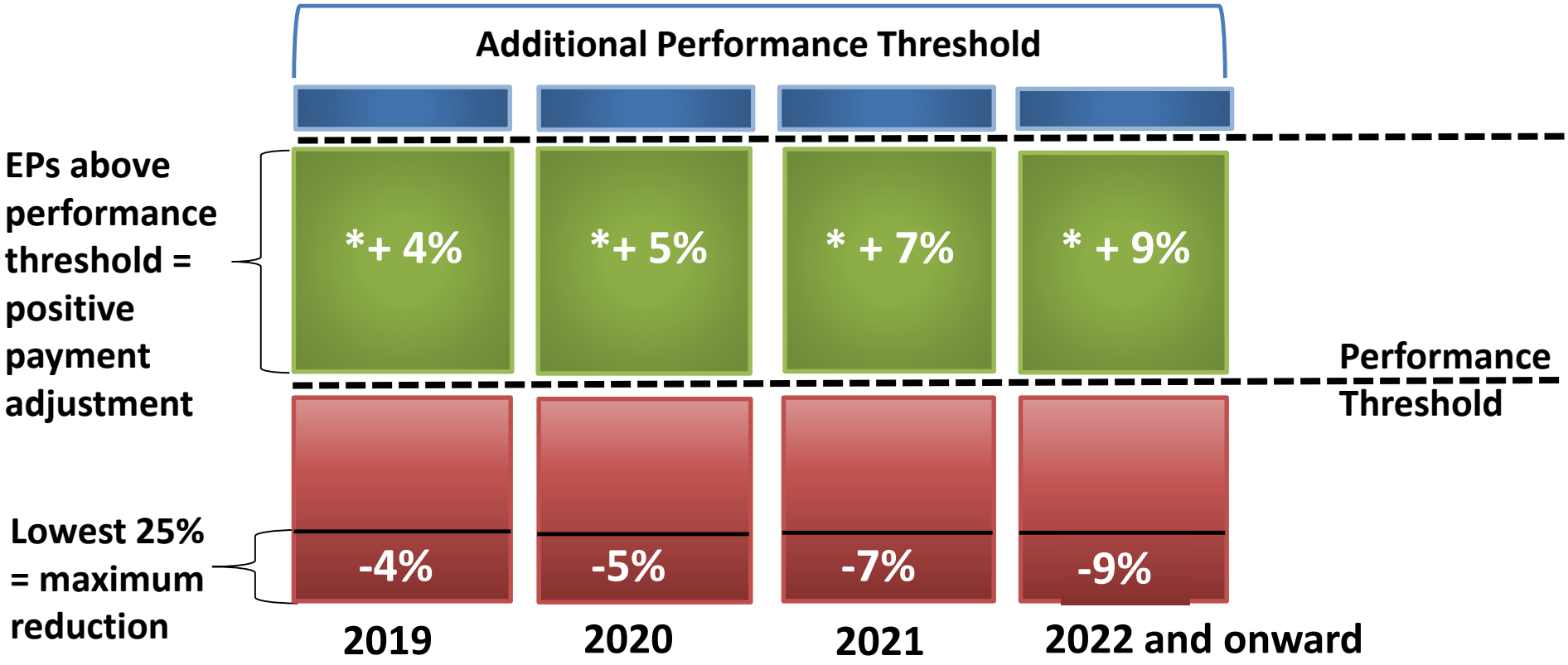
Calculating the Composite Performance Score (CPS) for MIPS

Category	Weight	Scoring
Quality	50%	• Each measure 1-10 points compared to historical benchmark (if avail.) • 0 points for a measure that is not reported • Bonus for reporting additional outcomes, patient experience, appropriate use, patient safety, care coordination and EHR reporting • Performance plus bonus points are added and divided by 10x the number of scored measures)
Advancing care information	25%	• Base score of 50 points is achieved by reporting at least one use case for each available measure • Up to 10 additional performance points available per measure • Total cap of 100 percentage points available
CPIA	15%	• Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target
Resource Use	10%	• 1-10 points based on performance period benchmark

✓ Unified scoring system:
1. Converts measures/activities to points
2. Eligible Clinicians will know in advance what they need to do to achieve top performance
3. Partial credit available

MIPS Incentive Payment Formula

Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024



**MACRA allows potential positive adjustments to be higher or lower than listed*

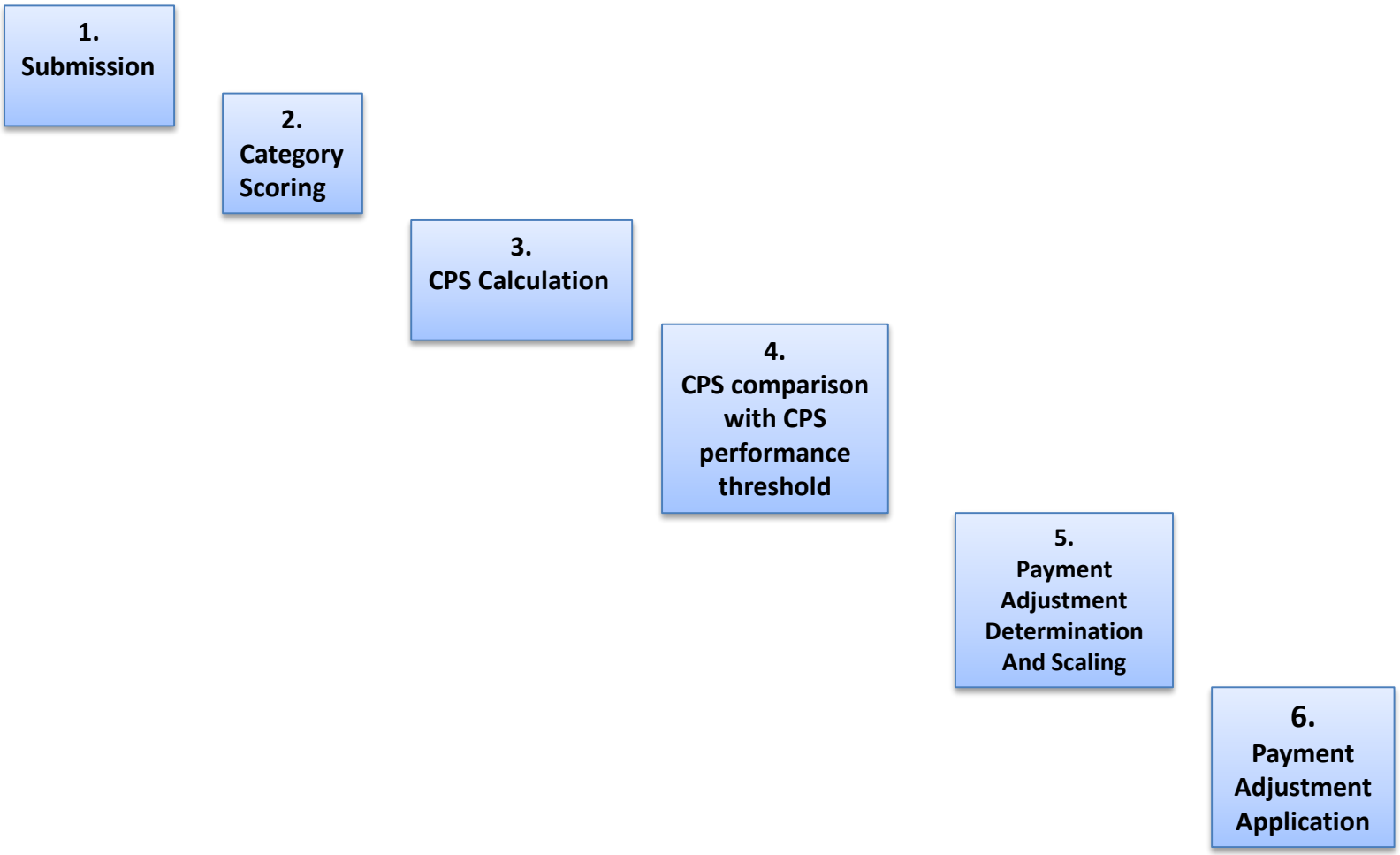
MIPS: SCORING METHODOLOGY OVERVIEW

MIPS Performance Categories

A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:

The CPS compared to "Performance Threshold" to determine payment adjustment.

Six Steps to Determining the MIPS Payment Adjustment



Steps to Determining the MIPS Payment Adjustment

1. Submission
2. Category Scoring
3. CPS Calculation
4. CPS comparison with CPS performance threshold
5. Payment Adjustment Determination And Scaling
6. Payment Adjustment Application

MIPS APM Entity

CPIA | Advancing Care Information | Quality

Individual EP (TIN/NPI)

Resource Use | CPIA | Advancing Care Information | Quality

Individual EP (TIN/NPI)

Group (TIN with multiple NPIs)

Resource Use | CPIA | Advancing Care Information | Quality

Between Steps 3 and 4

- Determine which TIN/NPIs are still in MIPS after exclusions.
- Assign the TIN/NPI the proper CPS score.
- Calculate an NPI CPS score that can be used if NPI bills under a new TIN

Payment Adjustment at TIN/NPI level for all Clinicians

SPECIAL SCORING STANDARDS FOR MIPS APMs

PROPOSED RULE
APM Scoring Standard

The APM scoring standard **applies to APMs that meet these criteria**:

- ✓ APM Entities participate in the APM under an **agreement with CMS**;
- ✓ APM Entities include one or more **MIPS eligible clinicians** on a Participation List; and
- ✓ APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on **cost/utilization and quality measures**.

- ✓ To be considered part of the APM Entity for the APM scoring standard, an eligible clinician **must be on an APM Participation List on December 31** of the MIPS performance year.
- ✓ Otherwise an eligible clinician must report to MIPS under the standard MIPS methods.

PROPOSED RULE
APM Scoring Standard

To which APMs will the APM scoring standard apply?

- ✓ **Shared Savings Program** (all tracks)
- ✓ **Next Generation ACO Model**
- ✓ **Comprehensive ESRD Care (CEC)**
- ✓ **Comprehensive Primary Care Plus (CPC+)**
- ✓ **Oncology Care Model (OCM)**
- ✓ **All other APMs** that meet criteria for the APM scoring standard

PROPOSED RULE

APM Scoring Standard
Shared Savings Program

	Reporting Requirement	Performance Score	Weight
Quality	✓ Shared Savings Program ACOs submit to the CMS Web Interface on behalf of their MIPS eligible clinicians.	✓ The MIPS quality performance category requirements and benchmarks will be used at the ACO level.	✓ 50%
Resource use	✓ No reporting requirement.	✓ N/A	✓ 0%
CPIA	✓ All MIPS eligible clinicians submit through ACO participant TINS according to the MIPS requirements.	✓ ACO participant TIN scores will be aggregated, weighted and averaged to yield one ACO level score.	✓ 20%
Advancing care information	✓ All MIPS eligible clinicians submit through ACO participant TINS according to the MIPS requirements.	✓ ACO participant TIN scores will be aggregated, weighted and averaged to yield one ACO level score.	✓ 30%

PROPOSED RULE

APM Scoring Standard
Next Generation ACO Model

	Reporting Requirement	Performance Score	Weight
 Quality	✓ Next Generation ACOs submit to the CMS Web Interface on behalf of their MIPS eligible clinicians.	✓ The MIPS quality performance category requirements and benchmarks will be used at the ACO level.	✓ 50%
 Resource use	✓ No reporting requirement.	✓ N/A	✓ 0%
 CPIA	✓ All MIPS eligible clinicians submit individually according to the MIPS requirements.	✓ ACO participant individual scores will be aggregated, weighted and averaged to yield one ACO level score.	✓ 20%
 Advancing care information	✓ All MIPS eligible clinicians submit individually according to the MIPS requirements.	✓ ACO participant individual scores will be aggregated, weighted and averaged to yield one ACO level score.	✓ 30%

PROPOSED RULE

APM Scoring Standard

All Other APMs under the APM Scoring Standard

	Reporting Requirement	Performance Score	Weight
 Quality	✓ No assessment for the first MIPS performance year. APM-specific requirements apply as usual.	✓ N/A	✓ 0%
 Resource use	✓ No reporting requirement.	✓ N/A	✓ 0%
 CPIA	✓ All MIPS eligible clinicians submit individually according to the MIPS requirements.	✓ APM Entity participant individual scores will be aggregated and averaged to yield one APM Entity level score.	✓ 25%
 Advancing care information	✓ All MIPS eligible clinicians submit individually according to the MIPS requirements.	✓ APM Entity participant individual scores will be aggregated and averaged to yield one APM Entity level score.	✓ 75%

STEP 1:

SUBMISSION

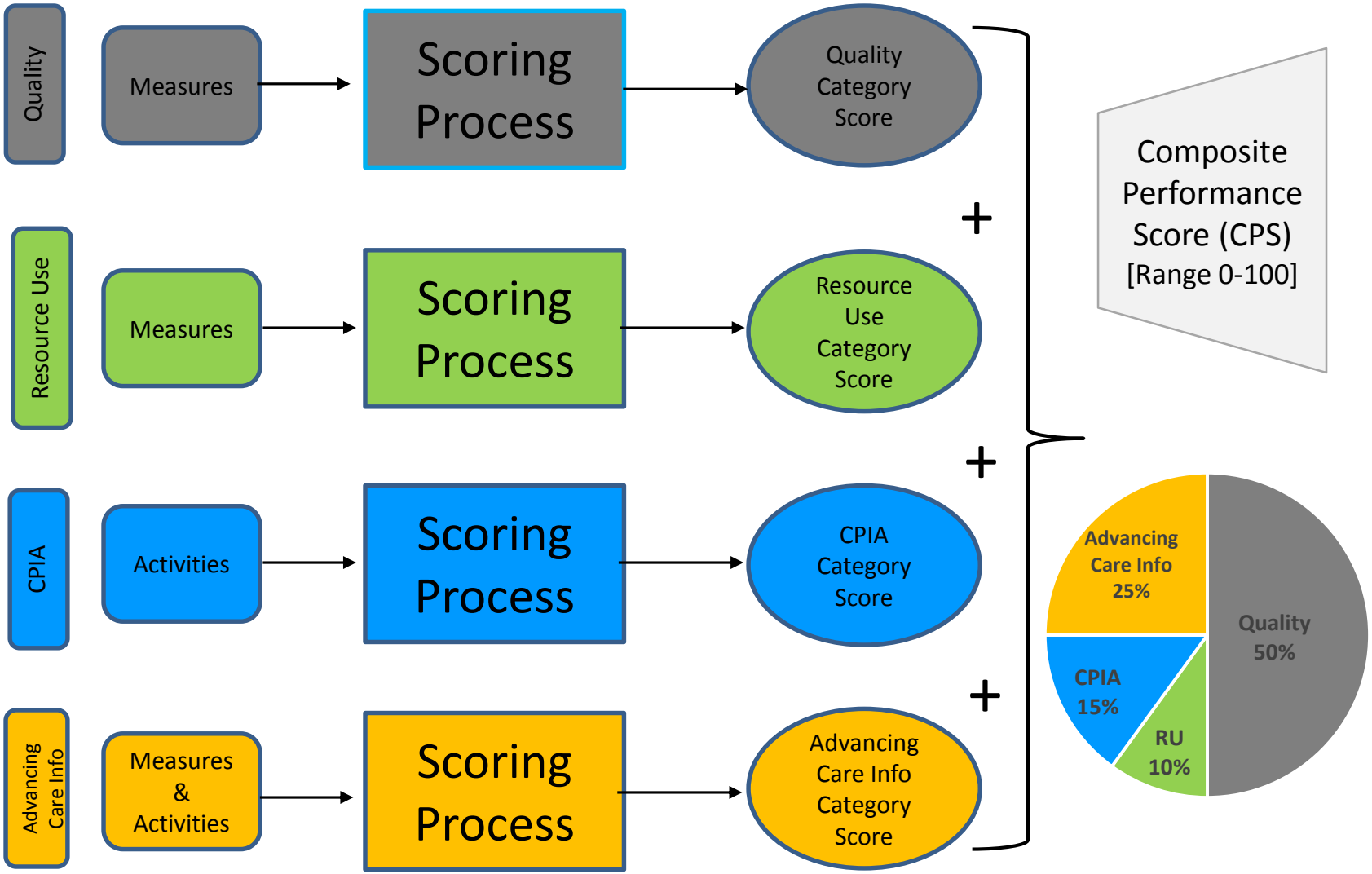
SUBMISSION

Performance Category	
	**Quality:** Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-priority measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.
	**Advancing Care Information:** Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.
	**Clinical Practice Improvement Activities:** Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn "full credit" in this category, and those participating in APMs will earn at least half credit.
	**Resource Use:** CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.

STEP 2:

CATEGORY SCORING

Scoring Rules for Each Category with General Themes



Unified Scoring Principles

- 10 point scoring system Actionable and transparent data. Eligible clinicians will know in advance what they need to do to perform well.
- Moves away from "all-or-nothing" scoring
  - Receive scores for submitted information
  - Performance at any level would help improve the CPS
  - Zero scores for any required items that are not submitted
- No improvement scoring for year 1
  - Seeking comment on how to implement improvement in future years.

Quality Performance Category Score

Measures Requirements: (Generally)

- EPs to submit 6 measures, including 1 high priority measure (outcome, appropriate use, patient safety, efficiency, care coordination or patient experience) and at least 1 cross-cutting measure (if EP is patient facing.)
  - If a required measure is not reported then EP receives 0 points for that measure
- PLUS
- Population measures from claims (acute composite, chronic composite, readmissions)

- Assign 1-10 points based on benchmark
  - Most benchmarks based on deciles
  - Topped out measures based on cluster approach

Other Rules:

- Minimum case volume required
- Bonus points:
- Up to 10% total in bonus points
- Additional high priority measures (up to 5%)
  - 2 bonus points awarded for additional outcome/patient experience;
  - 1 bonus point for other high priority measures
- CEHRT Bonus (up to 5%)
  - 1 bonus point for each measure using CEHRT in end-to-end electronic reporting
- Can only get bonus points if you have sufficient sample size, and performance rate >0

Resource Use Performance Category Score

- Measures:
  - Total Per Capita
  - Medicare Spending Per Beneficiary
  - Episode Measures
- Assign 1-10 points based benchmark
  - Benchmarks based on deciles
  - Benchmarks based on performance period (rather than baseline period)
- No bonus points
- Minimum case volume required
  - No performance category score if clinician is not attributed enough cases to meet minimum case volume

CPIA Performance Category Score

- Each activity is worth a certain number of points
  - Most are worth 10 points
  - Some activities have high weight 20 points
- To get maximum credit, must achieve at least 60 points (can be achieved by selecting combination of high- and medium-weighted activities, all high-weighted, or all medium-weighted activities)
- Rules for non-patient facing, small practices (15 or fewer professionals, practices located in rural areas and geographic health professional shortage areas
  - First activity gets 50% of the 60 points
  - Second activity gets 100% of the 60 points
  - Weight does not matter
- Eligible clinicians participating in an APM automatically receive a minimum half of highest potential score; but can increase by reporting additional activities
- Eligible clinicians participating in a certified patient-centered medical home receive highest potential score

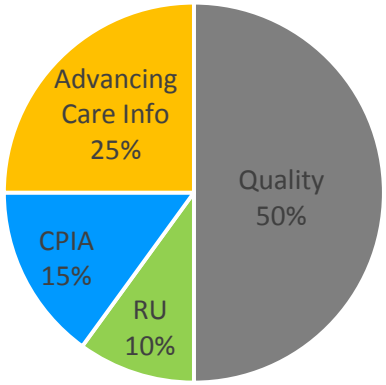
Advancing Care Information Performance Category

- The performance category score is capped at 100 percentage points (out of a possible 131 percentage points).
- 50 percentage points for the base score, which consists of:
  - Reporting privacy and security
  - Reporting a numerator/denominator or yes/no statement for each measure as required
    - Note: for numerator/denominator measures, ECs must report at least a one in the numerator; for yes/no statement measures, ECs must report a yes for credit.
- 80 percentage points for the performance score, which is determined based on achievement above the base score requirements for three objectives:
    - Patient Electronic Access, Coordination of Care Through Patient Engagement, Health Information Exchange
- 1 “bonus” percentage point for Public Health and Clinical Data Registry Reporting

STEP 3:

CPS CALCULATION

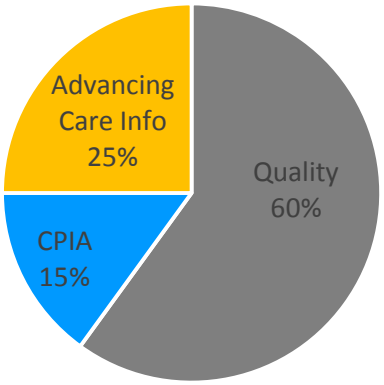
What happens when EP has missing performance category score?



Example

Year 1 Standard Category Weights

No resource use points /Reallocate to Quality



- **General proposal:**
  - If the quality category has at least 3 scored measures:
    - Reallocate 100 percent of the missing category points to quality
  - If quality has less than 3 scored measures:
    - Reduce the weight of the quality category
    - Reassign missing weights proportionately to the other categories
  - Anticipate that no Clinicians will have a missing CPIA performance category score
  - Clinicians must have at least 2 non-missing performance category scores or CPS =performance threshold

CPS Scoring Example for 2019 MIPS Payment Year: Different Ways to Obtain the Same Score

Eligible Clinician Has Average or Above Average Score in All Categories

Performance Category	Score	Weight	Weighted Score
Quality	60%	50%	30%
Resource Use	50%	10%	5%
CPIA	67%	15%	10%
Advancing Care Information	60%	25%	15%
Subtotal	n/a	100%	60%
Composite Performance Score (Subtotal x 100)			60 points

Eligible Clinician Excels in Quality; Does Not Earn Advancing Care Information

Performance Category	Score	Weight	Weighted Score
Quality	100%	50%	50%
Resource Use	50%	10%	5%
CPIA	67%	15%	10%
Advancing Care Information	0%	25%	0%
Subtotal	n/a	100%	60%
Composite Performance Score (Subtotal x 100)			60 points

MIPS Performance is the same for BOTH Clinicians so both Clinicians will receive the same adjustment factors.

What happens if…

- Clinician does not meet measure requirements?
  - Answer: they get zero points for the measure
- Clinician does not have sufficient sample size to calculate a quality score?
  - Answer: The measure is not included in the MIPS performance score. The EP is not scored a zero for a missing measure.
- Clinician reports more than 6 measures?
  - Answer: Score “high priority” and “cross-cutting” measures first – take the one with the best performance. Then take the remaining 4 (or 5) measures with highest performance.

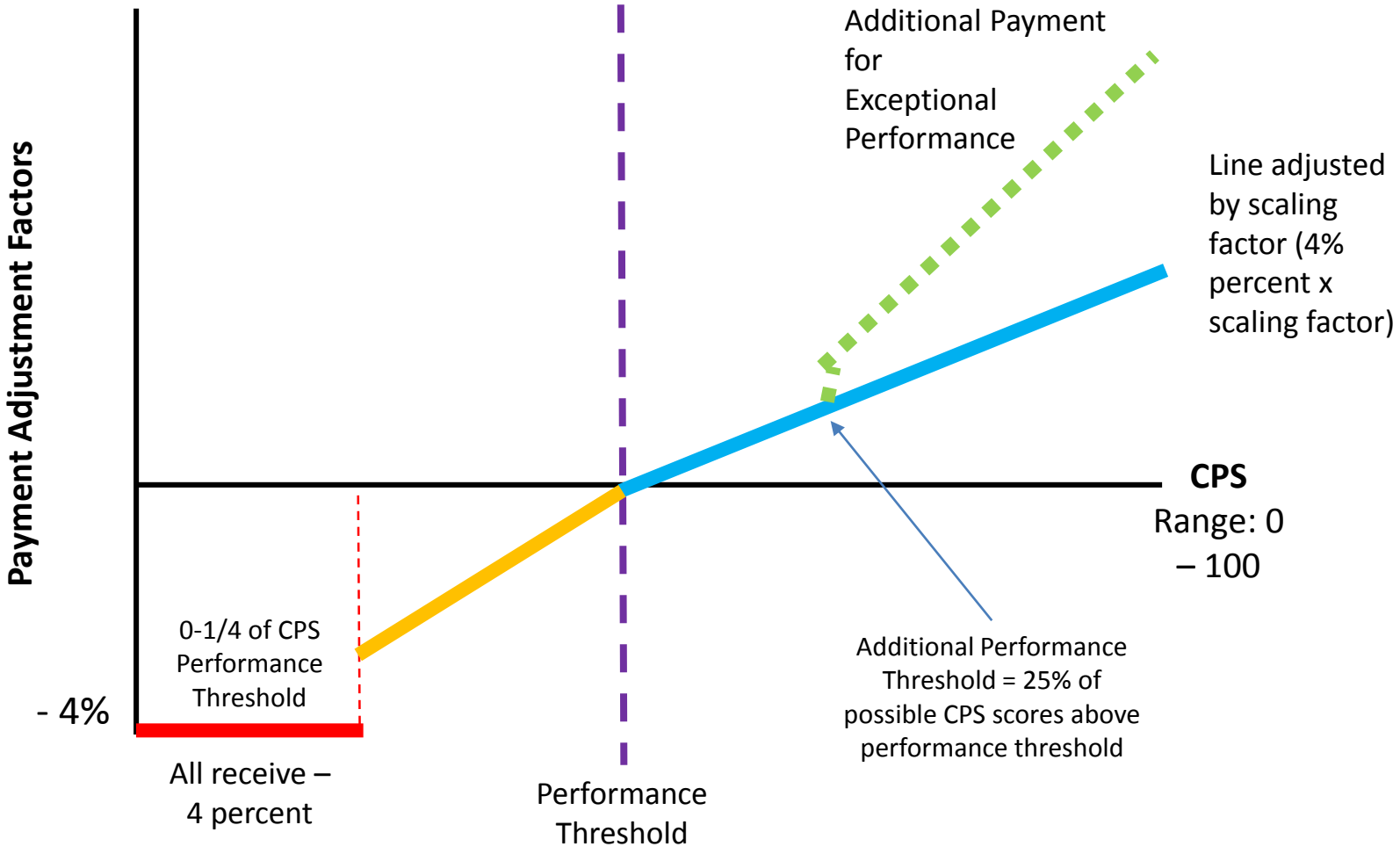
STEP 4:

CPS COMPARISON WITH CPS PERFORMANCE THRESHOLD

Relationship between CPS and Payment

EPs BELOW performance threshold have negative adjustment

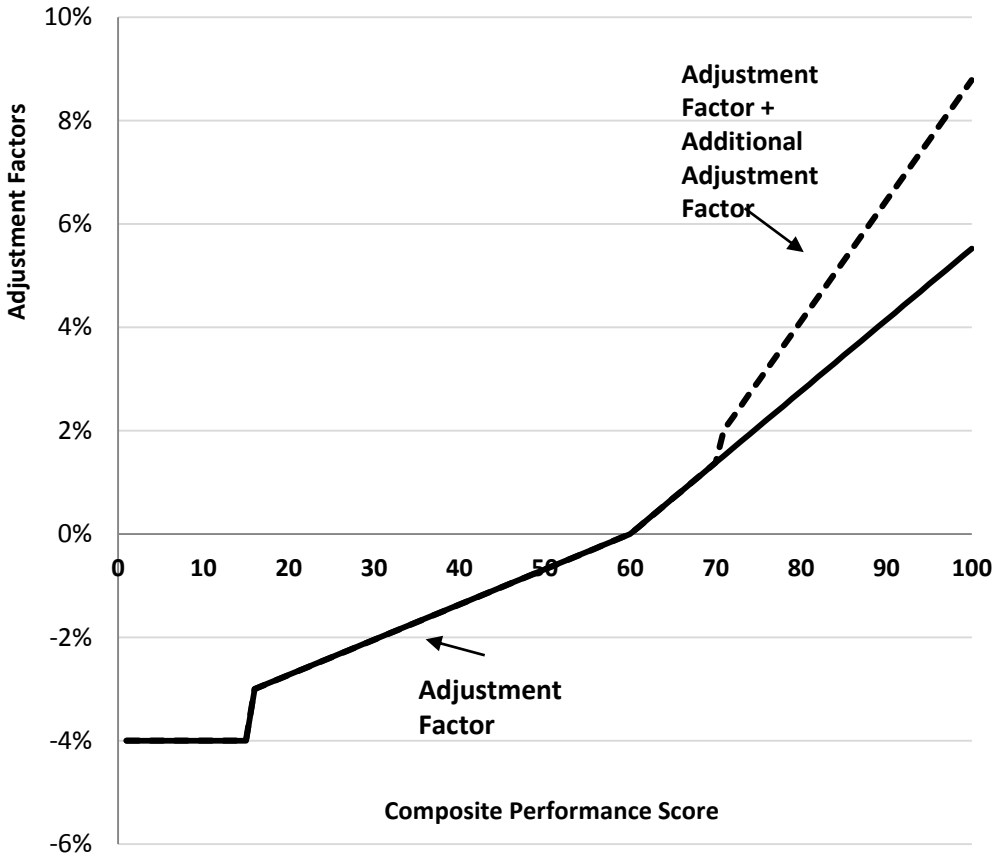
EPs ABOVE performance threshold have a positive adjustment



EXAMPLE: If Performance Threshold= 60

NOTE – ALL THE NUMBERS AND LINES IN THE CHART ARE DRIVEN OFF THE (Hypothetical) PERFORMANCE THRESHOLD AND WILL CHANGE IF PERFORMANCE THRESHOLD IS A DIFFERENT VALUE; also, THE POSITIVE ADJUSTMENT SLOPE WILL CHANGE IF THE DISTRIBUTION CHANGES

- CPS >=0 and CPS <=15 → adjustment factor = -4%
  - Scores between 0-¼ of the performance threshold always receive the max negative adjustment
- CPS >15 and CPS<60 → adjustment factor is > -4% and <0%
- CPS = 60 → adjustment factor = 0%
- CPS >60 and CPS < 70 → adjustment factor >0%
- CPS >=70 → total adjustment = adjustment factor >0% + additional adjustment factor >=0.5%
  - Scores greater than one quarter of the possible CPS above the performance threshold eligible for additional adjustment factor for exceptional performance



STEP 5:

PAYMENT ADJUSTMENT DETERMINATION AND SCALING

Identify MIPS Eligible Clinicians for Payment Adjustment

- Payment adjustment is at TIN/NPI level
- Exclude TIN/NPIs that meet exclusion criteria
  - Newly enrolled
  - Qualifying APM participant (QP)
  - Partial QP
  - Low volume threshold
- Pull the corresponding CPS score
  - See slide 48 for special cases
- Use CPS score for budget neutrality

STEP 6:

PAYMENT ADJUSTMENT APPLICATION

Composite Performance Score (CPS)

- Generally, the payment adjustment will be based on the TIN/NPI's CPS score from the performance
- Special rules
  - if the clinician has changed practices and bills under a new TIN
  - If a clinician has multiple submissions

Special Cases

What if a clinician changed groups after the performance period?

- **Performance follows the NPI**
- **If the NPI worked for 1 TIN in performance period, then eligible clinician's adjustment will be based on the old TIN/NPI CPS**
- **If the NPI worked for more than 1 TIN, we would take the weighted average of the TIN/NPI scores**
- **If the NPI did not have a score (because they did not bill claims), then the NPI is not in MIPS (Excluded due to low-volume in performance period or being newly enrolled)**

What if an EP has more than one submission?

- Example: Multiple APM submissions; an APM, group submission, individual submission

Proposal:

- Take APM scores over other scores. If multiple APM CPS, take the highest scores
- If no APM score – take the highest remaining score.

Key Takeaways

- Opportunities for incentives.
  - Once the performance threshold is determined, **ALL** eligible clinicians above the performance threshold will be eligible to receive positive payment adjustment.
  - There is no requirement that a certain number of clinicians receive negative adjustments!
- To get incentives, you must submit data.
  - If you do not submit data, the law requires us to give zero performance and negative adjustment
  - We want your feedback on the submission criteria
- Scoring has been redesigned so that clinicians can how they are doing.
  - Benchmarks known in advance
  - Want to make information useful and transparent
  - Provide feedback on the changes. What works? How can we improve?

THANK YOU!

More Ways to Learn To learn more about the Quality Payment Programs including MIPS program information, watch the http://go.cms.gov/QualityPaymentProgram to learn of Open Door Forums, webinars, and more.