Medicare Payment Under MIPS
What We Know Now (May 2016)

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PQRS, Value-Based Modifiers and Meaningful Use programs will all sunset with the 2018 payment year which is based on 2016 data. The Merit-Based Incentive Payment System or MIPS takes their place starting with the 2017 reporting year. Here's what we know now based on proposed rules. Final rules are expected in November, leaving very little time for practices to adapt processes and systems.

A single Composite Performance Score between 0 and 100 will be assigned to each clinician based on a combination of 4 component parts, each discussed in detail below.

Quality Reporting – PQRS vs MIPS (*Proposed)

	# OF MEASURES	REPORT ON	PERFORMANCE
2016 PQRS	9: 3 domains 1 cross-cutting	50% of eligible Medicare patients	>0% for PQRS Mean +/- 1 Stnd Dev for VBM
2017* MIPS	6: 1 outcome 1 cross-cutting	Claims-80% of eligible Medicare pts All Others- 90% of eligible pts (all payers)	Top decile = 10 points, reduce 1 point for each decile

- MIPS will not allow reporting via Measure Groups
- Each measure receives a score based on performance and bonus points
  - If <6 measures are reported and additional measures are available, then a score of zero is assigned for the missing measure(s)
  - 1 bonus point if measure is in 'high priority' category; 1 bonus point if data for measure is captured in certified EHR
  - Measures with <20 in denominator are not scored
- CMS adds up to 3 population-based measures calculated from claims data.
- Scores for all measures are summed and divided by maximum possible points for a single Quality Score (% of Maximum).

'Meaningful Use' Becomes 'Advanced Care Information' (*Proposed)

- In 2017, use either Modified Stage 2 measures or Stage 3 measures; Stage 3 required in 2018.
- Proposed to remove CDS and CPOE measures for both Modified Stage 2 and Stage 3.

Modified Stage 2 Scoring for Advanced Care Information – 2017 Reporting Year

BASE SCORE = 50 POINTS Receive Base Score by attesting Yes or Numerator = 1 or larger for each measure below
Security Risk Analysis
E-prescribing
Patient Access to Data
Pt View/Dwnld/Transmit Data
Patient Specific Education
Secure Messaging
Health Info Exchange
Medication Reconciliation
Immunization Registry[1]
Syndromic Surv. Registry[2]
Specialized Registry[2]

PERFORMANCE SCORE = UP TO 80 POINTS For each measure listed, score 1 point for each 10% in performance (i.e., 100% = 10 points, 99%=9.9 points, 98% = 9.8 points)
Patient Access to Data
Patient Specific Education
Patient View/Download/ Transmit Data
Secure Messaging
Patient Generated Data (Stage 3)
Health Info Exchange
Accept Elec Summary of Care (Stage 3)
Clinical Info Reconciliation

[1] Respond Yes if meet exclusion
[2] Add 1 bonus point if reporting

Resource Use – VBM vs MIPS (*Proposed)

- Removed Per Capita Cost for 4 Chronic Conditions Measure. Added 40 Episode-Specific Per Capita Cost measures. For example, claims data is used to identify all services within an episode of care for Knee Replacement surgery. Average Cost per attributed episode is calculated.
- Technical adjustments to Per Capita Cost and Medicare Spending per Benficiary (MSPB) measures
- Each measure receives a score of 1 to 10. Top decile = 10 points; reduce 1 point for each lower decile. Scores for all measures are summed and divided by maximum possible points for a single Resource Use Score (% of Maximum).

Clinical Practice Improvement Activities (CPIA)

- CMS provides list of 90 activities and rates each as 'Medium' (10 points) or 'High' (20 points). Examples of activities: patient reminders for preventive services (medium), patient satisfaction survey (medium), see new and follow-up Medicaid patients in a timely manner (high), consult RX monitoring program prior to prescribing opioids (high).
- Attest to activity occurring during any 90-day period in the calendar year.
- Full Credit for this Category achieved by any of the following:
  - 60 points (combination of medium and high rated activities)
  - For small practices (<15 providers) or those located in rural or HPSA designations, any 2 activities
  - PCMH or PCSP recognition from NCQA, AAAHC, Joint Commision or URAC
- 50% Credit for this Category if participating in an Advanced Payment Model of any type

The Composite Performance Score (CPS) for 2017 Reporting Year

EXAMPLES	WEIGHT	SCORE	MAX POSSIBLE	% OF MAX	WEIGHTED SCORE
Quality	50%	51.00	90	56.67	28.33
Advanced Care Information (MU)	25%	72.69	100	72.69	18.17
Performance Improvement (CPIA)	15%	60.00	60	100.00	15.00
Resource Use	10%	25.90	40	64.75	6.48
COMPOSITE PERFORMANCE SCORE					**67.98**

2019 Medicare Payment Rate Adjustments

	CPS	INITIAL ADJ	EST ADD'L INCENTIVE
MAXIMUM SCORE	**100**	**4.0%**	**10.0%**
	95	3.5%	7.9%
	90	3.0%	6.3%
	85	2.5%	4.8%
	80	2.0%	3.2%
	75	1.5%	1.6%
(Max-Threshold) x 25%	70	1.0%	0.5%
EXAMPLE SCORE	**67.98**	**0.8%**	
	65	0.5%	
THRESHOLD	**60**	**0.0%**	
	55	-0.3%	
	50	-0.7%	
	45	-1.0%	
	40	-1.3%	
	35	-1.7%	
	30	-2.0%	
	25	-2.3%	
	20	-2.7%	
THRESHOLD x 25%	**15**	**-4%**	

- CMS will set a Threshold Score based on a historical national average. In this example, we've set it at 60 however the actual threshold for 2017 will not be known until November when final rules are published.
- The Initial Adjustment columns shows the increase or decrease that providers with specific scores would receive on 2019 payments based on their CPS.
- Adjustments must be budget neutral meaning that the amount paid out in positive adjustments must equal the amount saved through negative adjustments across all providers. Maximum reduction is set at 4% for 2019 by statute and increases to 9% by 2022. The positive adjustment cannot be more than 3 times this amount (12% in 2019).
- Additional incentives of $500 million will be distributed to those with the highest CPS scores. Proposed distribution formula is shown in chart.