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

2018 Merit-Based Incentive Payment System (MIPS) Scoring Overview
What is MIPS?

2018 is the second year of the MACRA Quality Payment Program (QPP). While 2017, the first year of the QPP, served as a transition year. MIPS consolidates and sunsets the previous quality reporting programs by the Centers for Medicare and Medicaid Services (CMS), 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.

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).

What are the weights of each category?

Unlike in 2017 when only three categories were scored, in 2018 all four MIPS categories will be scored: quality (50%), based on PQRS; cost (10%), based on VM; advancing care information (ACI) (25%), based on Meaningful Use; and improvement activities (15%), a 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. There is a two-year gap between the performance year and the payment adjustment year. Therefore, 2018 MIPS performance will be used to assess the 2020 payment adjustment.

How will CMS calculate your MIPS performance score in 2018 and 2020 payment adjustment?

For the 2018 performance year, CMS set the performance threshold at 15 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.

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1 For 2018, the minimum threshold to avoid a penalty was established by CMS through 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.
2018 MIPS bonus points

Additional bonus points can be achieved for treating complex patients or being in a small practice. However, they must participate in MIPS by submitting data for at least 1 MIPS performance category.

<table>
<thead>
<tr>
<th>Small Practice Bonus</th>
<th>Complex Patient Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined as 15 or fewer eligible clinicians.*</td>
<td>Physicians and other clinicians can have up to 5 bonus points to their MIPS final score for treating complex patients</td>
</tr>
<tr>
<td>Physicians and other clinicians in small practices will have 5 bonus points added to their MIPS final score.</td>
<td>Number of points is determined based on a combination on the number of dual eligible patients (those in Medicare and Medicaid) and the Hierarchical Condition Category (HCC) scores</td>
</tr>
<tr>
<td></td>
<td>Complex patient bonus for MIPS ECs and groups = Average HCC score assigned to beneficiaries + (Dual eligible ratio * 5)</td>
</tr>
</tbody>
</table>

*For 2018, eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.

The infographic below summarizes the formula of how the 2018 MIPS performance scores are calculated.

\[
(\text{quality score} \times 50\%)(100) + (\text{improvement activities score} \times 15\%)(100) + (\text{ACI score} \times 25\%)(100) + \text{small practice bonus (if applicable)} + \text{complex patient bonus (if applicable)} = 2018 \text{ MIPS final score}
\]

To avoid a negative payment adjustment, the 2018 MIPS final score must be \( \geq 15 \)
How are the scores for each category calculated?

Quality Category Scoring

There are three parts to the quality category score: 1) the points received for each reported measure, 2) bonus points for measures, and 3) improvement scoring points.

Individual, Group, and Virtual Group Reporting

Under the individual, group, and Virtual Group reporting options, physicians receive 1-10 points for each measure based on their performance compared to a benchmark. Solo practitioners and small practices of 15 or fewer eligible clinicians (ECs) will automatically receive 3 points for submitting some information on a measure, while practices with more than 15 ECs will automatically receive 1 point for submitting some information on 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 2018, generally, 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

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2 Based on historical measures performance data, it is possible that some measures may have fewer than eight applicable and scored deciles, but maximum scores can still be achieved for these measures.
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.

<table>
<thead>
<tr>
<th>2018 Deciles</th>
<th>Points Assigned for 2018 MIPS Performance</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 2018 Quality Benchmarks WinZip file available on the CMS QPP Resource Library. 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.

Measures with No Benchmark

For quality measures with no historical benchmark, CMS will calculate benchmarks based on 2018 data. If no benchmark can be calculated, then only a maximum of 3 points can be earned for the measure, as long as data completeness criteria has been met. For additional information on the data completeness criteria, see PAI’s Quality Category Overview on the MIPS Pathway page.

Topped Out Measures

For quality measures designated as “topped out,” only a maximum of 7 points can be earned. Topped out measures are defined as measures for which performance is consistently high that “meaningful differences and improvement in performance can no longer be seen.” CMS has identified 6 topped out measures for 2018.
### Bonus Points for Measures

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>

### Improvement Scoring

Improvement scoring is available for demonstrating an improvement in performance in the quality category as a whole in the current year as compared to the previous year. Up to 10 bonus points can be earned for the quality category based on the rate of improvement in the quality category performance. The following formula will be used:

\[
\text{Quality Improvement Score} = \frac{\text{Increase in Quality Category Score}}{\text{Previous Period’s Quality Category Score}} \times 10\%
\]

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 for measures that were received, 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), and adding the improvement scoring bonus points.

For groups or Virtual 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.

**Group and Virtual Group Reporting of 25 or more eligible clinicians**

A similar approach is taken for groups or Virtual Groups (referred collectively as “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 CMS Web Interface measures. The benchmarks for the CMS Web Interface measures are the same as the Medicare Shared Savings Program (MSSP) performance benchmarks, but the scoring will be adjusted to be consistent with other MIPS measures.

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 also be counted as a scored measure. 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, and to earn an improvement scoring bonus.
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).

While the maximum number of points you may achieve for the quality category can be over 100, the maximum score you can achieve for the quality category is 100%.

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 statement or a 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 additional 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 charts demonstrate what this would look like for a performance score measure worth up to 10 points and up to 20 points.

<table>
<thead>
<tr>
<th>Performance Rate for Up to 10 Points</th>
<th>Points Assigned for 2018 MIPS Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 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>

<table>
<thead>
<tr>
<th>Performance Rate for Up to 20 Points</th>
<th>Points Assigned for 2018 MIPS Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 10%</td>
<td>2</td>
</tr>
<tr>
<td>11% - 20%</td>
<td>4</td>
</tr>
<tr>
<td>21% - 30%</td>
<td>6</td>
</tr>
<tr>
<td>31% - 40%</td>
<td>8</td>
</tr>
<tr>
<td>41% - 50%</td>
<td>10</td>
</tr>
<tr>
<td>51% - 60%</td>
<td>12</td>
</tr>
<tr>
<td>61% - 70%</td>
<td>14</td>
</tr>
<tr>
<td>71% - 80%</td>
<td>16</td>
</tr>
<tr>
<td>81% - 90%</td>
<td>18</td>
</tr>
<tr>
<td>91% - 100%</td>
<td>20</td>
</tr>
</tbody>
</table>

Additional bonus points (up to a total of 25 points) can be achieved for reporting a public health/clinical data registry measure, by using CEHRT to report improvement activities, and by using only 2015 Edition CEHRT.

<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>
<tr>
<td>Using only 2015 Edition CEHRT</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-

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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 ACI 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. The cost category will have a weight of 10% of the 2018 MIPS final score. CMS will use administrative claims data to assess
performance on the following 2 cost measures: Medicare Spending Per Beneficiary (MSPB) measure and the Total Per Capita Cost (TPCC) measure.

Physicians must meet the case minimum requirements for each measure in order to have the measures count towards the cost category performance score. If the case minimum is not met for one measure, then the cost category weight will be based solely on the remaining measure. If the case minimum is not met for both measures, then the cost category will be reweighted to 0% and the quality category will be reweighted to 60%, ACI weight would be 25% and, the improvement activities weight would be 15%.

The score for the cost category will be determined using an approach that is similar to that used for the quality category measures. Physicians will receive 1-10 points for each of the applicable two cost measures based on their relative performance in the measures compared to the measures’ benchmarks. Unlike the quality category, physicians will not automatically receive a minimum number of points for these measures. Additionally, unlike the quality category measure benchmarks, the cost category measure benchmarks are not based on previous year data; cost category measure benchmarks are determined using the performance year data and seeing how physicians performed compared to their peers. Further details on the scoring are provided in the appendix.

Improvement Scoring for Cost Measures

Improvement scoring is available for cost measures based on the number of measures with a “statistically significant” change (improvement and decline). Up to 1 bonus point can be earned for the cost category. The following formula will be used:

\[
\text{Cost Improvement Score} = \frac{(# \text{cost measures with improvement} - # \text{cost measures with decline})}{\text{total number of cost measures that were scored for two consecutive periods}} \times 1\% \times 10\%
\]

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3 CMS will not be utilizing the previously finalized 10 episode-based measures for 2018 MIPS participation and is in the process of developing new episode-based measures with stakeholder input for 2019 MIPS participation.

4 Based on the application of a t-test.
MIPS Case Study Example

Dr. Jane Doe operates an independent family medicine practice and has decided to participate in MIPS for the 2018 performance year. Dr. Doe submits data for the quality, improvement activities, and ACI MIPS categories for 2018 using a qualified clinical data registry (QCDR). Her quality category score is 58%, improvement activities category score is 100%, ACI category score is 68%, and cost category score is 25%. Additionally, because she is a solo practitioner, she meets the criteria for receiving the small practice bonus, and she receives a 1.2 complex patient bonus.

Her 2018 MIPS final score will be calculated as follows:

\[
\text{Quality (.58*.50)(100) + Improvement Activities (1*.15)(100) + ACI (.68*.25)(100) + Cost (.25*.10)(100) + 5 Small Practice Bonus + 1.2 Complex Patient Bonus} \\
\text{Quality 29 + Improvement Activities 15 + ACI 17 + Cost 2.5 + 5 Small Practice Bonus + 1.2 Complex Patient Bonus = 69.7 MIPS Final Score}
\]

Because her final score is 69.7 points, and above the 15-point threshold for 2018, Dr. Doe will receive a positive payment adjustment of her 2020 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.

Where can I go for more information?

To learn more about each of the MIPS category reporting requirements, please see the category overview resources available on PAI’s MIPS Pathway page.

Visit the PAI QPP Resource Center and the CMS QPP Resource Library for more information.
Appendix

Medicare Spending Per Beneficiary (MSPB)

Numerator = sum of the ratios of observed to expected costs for all MSPB episodes

Denominator = total number of MSPB episodes

Exclusions:

- Beneficiary not continuously enrolled in both Medicare Parts A and B from 93 days prior to the index admission through 30 days after discharge
- Beneficiary’s death occurred during the episode
- Beneficiary enrolled in a Medicare Advantage plan or Medicare is the secondary payer at any time during the episode or 90-day lookback period
- Index admission for the episode did not occur in a subsection (d) hospital paid under the Inpatient Prospective Payment System (IPPS) or an acute hospital in Maryland
- Discharge of index admission occurred in the last 30 days of the performance period
- Index admission involved in an acute-to-acute hospital transfer (i.e., the admission ends in a hospital transfer or begins because of a hospital transfer)
- Index admission occurs within the 30-day post-discharge period of another MSPB episode
- Index admission inpatient claim indicates a $0 actual payment or a $0 standardized payment

7 Steps for Calculating the MSPB Measure:

1. Define the population of index admissions
2. Calculate payment-standardized episode costs
3. Calculate expected episode costs
4. Exclude outliers
5. Attribute episodes to a TIN-NPI
6. Calculate the MSPB for the TIN-NPI (if reporting as a solo practitioner) or TIN (if reporting as a group or Virtual Group)
7. Report the MSPB measures for the TIN-NPI or TIN

Information based on CMS’s Cost Category Measure Specifications available on the CMS QPP Resource Library.
Define Population of Index Admissions

- MSPB episodes include all Medicare Parts A and B claims, and begin 3 days prior to a hospital admission and end 30 days after hospital discharge.

Calculate Payment-Standardized MSPB Episode Costs

- Calculated by summing all standardized Medicare claims payments made during the episode window.
- Episodes are payment-standardized to account for payment factors unrelated to provisions of care, e.g., add-on payments for education and geographic variations.

Calculate Risk-Adjusted Expected MSPB Episode Costs

- Expected costs are calculated using a model based on the CMS Hierarchical Condition Category (CMS-HCC) risk adjustment methodology for Medicare Advantage (MA), with a few differences, and with the inclusion of interactions terms between HCCs and/or enrollment status variables.

Exclude Outliers

- Statistical outliers are excluded to mitigate the effect of high- and low-cost episodes.

Attribute Episodes to TIN-NPI

- Attribution based on the TIN-NPI responsible for providing the plurality of Part B Physician/Supplier services during the index admission.

Calculate MSPB Measure for Each TIN-NPI or TIN

- Measure calculated by (i) calculating the ratio of the standardized observed episode costs to expected episode costs, and (ii) multiplying the average cost ratio across the episodes by the national average episode cost.

Report MSPB Measure for Each TIN-NPI or TIN

- Although the MSPB is attributed at the TIN-NPI, the reporting for the measure can be either at the TIN-NPI (solo practitioner level) or the TIN (group level).
Total Per Capita Costs

Numerator = sum of annualized, risk- & specialty-adjusted Parts A & B costs for attributed beneficiaries
Denominator = number of Medicare beneficiaries attributed to TIN-NPI

Exclusions:

- Beneficiaries not enrolled in both Medicare Part A and Part B for every month during the performance period, unless part year enrollment was result of new enrollment or death
- Beneficiaries were enrolled in a private Medicare health plan for any month during the performance period
- Beneficiaries resided outside the US, its territories, and its possessions during any month of the performance period

7 Steps for Calculating the Total Per Capita Cost (TPCC) Measure:

1. Attribute beneficiaries to TIN-NPI*
2. Calculate payment-standardized per capita costs
3. Annualize costs
4. Risk-adjust costs
5. Specialty-adjust costs
6. Calculate the TPCC measure for the TIN-NPI or TIN
7. Report the TPCC measure for the TIN-NPI or TIN

*The final details of the attribution methodology continue to be refined and described by CMS. There may be some small differences between this attribution methodology and the specific methodology used for other programs. For example, a beneficiary attributed under Voluntary Alignment where allowed (Shared Savings Program and Next Generation ACO) may be attributed for cost category purposes to an ACO non-Participant under the plurality of Part B charges during the index admission. Additionally, timing used for both retrospective and prospective Attribution for Shared Savings Program, Next Generation ACOs, Comprehensive Primary Care Plus (CPC+), ESRD Seamless Care Organizations and other programs may also find differences in individual beneficiary attribution for cost category purposes from the methodology used for those programs.
### Step 1: Attribute beneficiaries to TIN-NPI

- Two-step process that takes into account the level of primary care services received and the clinician specialties that performed those services.

### Step 2: Calculate Payment-Standardized Per Capita Costs

- Measure is payment-standardized to account for payment factors unrelated to provisions of care, e.g., add-on payments for education and geographic variations.

### Step 3: Annualize Costs

- Costs are annualized by dividing the total payment standardized costs for each beneficiary by the fraction of the year the beneficiary had both Medicare Parts A and B coverage.
- This is to account for new enrollees and those who died during the performance period.

### Step 4: Risk-Adjust Costs

- Costs risk-adjusted based on CMS-HCC risk score and End Stage Renal Disease (ESRD) status, and then comparing the actual per capita costs with expected per capita costs, and multiply by average non-risk-adjusted cost across all attributed beneficiaries.

### Step 5: Specialty-Adjust Costs

- CMS applies a specialty adjustment to account for cost variations across specialties.

### Step 6: Calculate TPCC Measure

- Measure calculated through Steps 1-5 and equivalent to numerator/denominator.

### Step 7: Report TPCC Measure for Each TIN-NPI or TIN

- Although the MSPB is attributed at the TIN-NPI, the reporting for the measure can be either at the TIN-NPI (solo practitioner level) or the TIN (group level).

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1. [http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Background-Resources/Reporting%20Mecanisms.pdf](http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Background-Resources/Reporting%20Mecanisms.pdf)
http://www.physiciansadvocacyinstitute.org/MACRA-QPP-Center/MIPS-Pathway
http://www.physiciansadvocacyinstitute.org/MACRA-QPP-Center/MIPS-Pathway
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