Navigating Medicare’s Quality Payment Program: MIPS Quality and Cost Categories
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The Physicians Advocacy Institute (PAI) is a not-for-profit organization that was established to advance fair and transparent policies in the health care system to sustain the profession of medicine for the benefit of patients.

As part of this mission, PAI seeks to better understand the challenges facing physicians and their patients and also educate policymakers about these challenges.

PAI also develops tools to help physicians prepare for and respond to policies and marketplace trends that impact their ability to practice medicine.

Information about PAI can be found at physiciansadvocacyinstitute.org.
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Guide to the PAI MACRA Educational Series

• **Overall purpose** – Program of materials and resources that provide context, an overview of core concepts and requirements, and an in-depth discussion of important topics

• **MACRA overview** – Foundational presentation and associated webinars to include a focus on meeting requirements for the 2017 transition period. Includes different sections on aspects of MACRA’s Quality Payment Program.

• **Follow-on products in early 2017** – In-depth one-pagers and monographs focused on topics such as the MIPS scoring system and strategies for reporting

• **In development** – Guide to additional resources in physician communities
Acronyms

• ACI – Advancing Care Information Category
• APMs – Alternative Payment Models
• CEHRT – Certified EHR Technology
• EHR/EMR – Electronic Health Registry; Electronic Medical Record
• MACRA – Medicare Access and CHIP Reauthorization Act
• MIPS – Merit-Based Incentive Payment System
• PQ – Partially Qualifying Advanced APM Participant
• QCDR – Qualified Clinical Data Registry
• QP - Qualifying Advanced APM Participant
• QPP – Quality Payment Program
What to find in this presentation . . .

1) **Merit-Based Incentive Payment System (MIPS) Overview** (slide 8)
   - Participation Eligibility and Exemptions (slide 9)
   - Reporting Options (slide 13)

2) **2017 Transition Year Minimum Reporting Options** (slide 15)

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   - Quality Breakdown of “50% of applicable patients” Requirement (slide 21)
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4) **MIPS Cost Category** (slide 26)

5) **Reporting Timeline** (slide 28)

6) **Next steps and Looking Forward** (slide 29)
Merit-based Incentive Payment System (MIPS) Overview
Who does QPP affect and who is required to participate in MIPS?

• The program will eventually include almost all clinicians who bill for Medicare Part B services; this will be phased in over time

• “Eligible Clinicians” subject to MIPS in 2017:
  • Physicians
    • Physician means doctor of: medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, optometry, and, with respect to certain specified treatment, doctor of chiropractic legally authorized to practice by a State in which he/she performs this function
  • Physician Assistants
  • Nurse Practitioners
  • Clinical Nurse Specialists
  • Certified Registered Nurse Anesthetists

• “Eligible Clinicians” may be expanded in 2019 to also include:
  • Physical or occupational therapists
  • Speech language pathologists
  • Audiologists
  • Nurse midwives
  • Clinical social workers
  • Clinical psychologists
  • Dieticians or nutrition professionals
Some eligible clinicians are exempt from MIPS. . .

Exempted from MIPS

- Newly-enrolled Medicare physicians, who enroll in Medicare for the first time during the performance year
- Physicians and groups that are below the low-volume threshold:
  - Who have Medicare Part B allowed charges $\leq 30,000$
  - OR
  - Who provide care to 100 or fewer Medicare Part B patients
- Physicians who are participating in Advanced APMs

CMS estimates - CMS estimates that 32.5% of eligible clinicians will be exempt from MIPS in 2017 because of the low-volume threshold

CMS will make available an NPI-level lookup tool on its QPP website later this year to assist physicians and other clinicians in determining if they are below the low-volume threshold, and therefore excluded from MIPS participation in 2017

- Practice Tip: Physicians should keep a record of the eligibility/exemption status provided by CMS
Participation options for physicians

- Physicians can participate either as individuals or as a group, but they must participate the same way across all four categories.

- As an individual
  - Physicians would report under an NPI number and the tax identification number (TIN) of the practice to which they reassign their benefits.

- As a group
  - 2 or more physicians (2 or more NPIs) who are part of the same practice with the same TIN.
  - Specific reporting requirements and certain reporting options are available for groups of 25 or more physicians.
  - All physicians in the group would receive the same aggregated scoring and corresponding payment adjustment across the group.

- Additionally, all physicians in a practice must participate the same way – either individually, or as a group.
  - For example, in a practice of 10 physicians all under the same TIN, the practice can elect to participate at the group level (the group of 10 physicians would collectively have to meet the specific requirements for each category) or decide that each of the 10 physicians would report as individual physicians (each physician would have to meet the specific requirements for each category).
MIPS performance categories - overview

**Quality**
- Builds off Physician Quality Reporting System
- Report 6 measures, including 1 outcomes measure or a specialty-specific measures set
- Primary factor early on -- 60% of score for 2019 payment adjustment

**Cost**
- Builds off Value-based Modifier
- New cost measures being developed for 2018
- No data reported; CMS uses administrative claims data to assess performance
- Implementation eased as costs are 0% of score for 2019 payment adjustment

**Advancing Care Information**
- Builds off Meaningful Use and encourages greater use of health information technology
- Report required 4 or 5 measures for base score
- 25% of score for 2019 payment adjustment
- Challenging area for many physicians

**Improvement Activities**
- New category
- Rewarding engagement in clinical practice improvement activities
- Report any combination of high and medium weight activities to achieve 40 total points
- 15% of score for 2019 payment adjustment
## Reporting mechanisms and options

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Claims, QCDR, Qualified Registry, EHR</td>
</tr>
<tr>
<td>Group</td>
<td>QCDR, Qualified Registry EHR, CMS Web Interface (groups of 25 or more eligible clinicians), CMS-approved survey vendor for CAHPS (used in conjunction with another reporting mechanism), Administrative Claims</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>No submission required. CMS will use administrative claims data.</td>
</tr>
<tr>
<td>Group</td>
<td></td>
</tr>
</tbody>
</table>
# Selecting the best option...

<table>
<thead>
<tr>
<th>Reporting Mechanism</th>
<th>Pros/Cons</th>
</tr>
</thead>
</table>
| Claims                       | The affordable option  
|                              | Share responsibility with billing companies  
|                              | Confusion and inaccurate reporting of codes for the quality measures  
|                              | Not available for all categories (only available for individuals for the quality category)                                                                                                                                                                                     |
| Attestation                  | No submission of data is required; another affordable option  
|                              | Must keep records for audit purposes                                                                                                                                                                                                                                          |
| QCDR/Qualified Registry      | These can be specialty-specific and offer more applicable quality measures; but also may be more limited in scope  
|                              | Physicians must pay a registration fee and additional fees for data integration services; however, some national specialty societies offer this option at no or low cost to members  
|                              | Difficulty linking to EHR systems and automatically extracting the data (often requires manual data entry)  
|                              | Requirement for “all-payer data”                                                                                                                                                                                                                                              |
| EHR                          | Many practices already use EHRs in daily practice (but not all practices have access to EHRs)  
|                              | Vendor submits the data on your behalf, but you must trust that vendor will correctly and accurately submit the information  
|                              | Depending on the measures selected and number of applicable patients, may be more advantageous to use an EHR than a specialized registry  
|                              | Limited availability of applicable quality measures that can be reported via an EHR                                                                                                                                                                                            |
| CMS Web Interface            | Only for groups of 25 or more physicians and eligible clinicians  
|                              | Higher reporting thresholds for Quality measures (must report more measures)  
|                              | Must register by June 30, 2017                                                                                                                                                                                                                                               |
| CAHPS                        | Must register by June 30, 2017  
|                              | Must be reported in conjunction with another reporting mechanism                                                                                                                                                                                                                 |
| Administrative Claims        | No submission is required  
|                              | Uncertainty about your performance and how CMS will use the data in its calculations                                                                                                                                                                                             |
2017 Transition Year Minimum Reporting Options
2017 “Transition Year” – Opportunities for easy participation

Don’t Participate
• Submit no data
• -4% payment adjustment in 2019

Test – Submit Something
• Submit a minimum amount of data
• Avoid negative payment adjustment

Partial – Submit Partial Year
• Submit 90-days worth of data
• Avoid negative payment adjustment
• Eligible for maximum positive payment adjustment

Full – Submit Full Year
• Submit data for all 2017
• Avoid negative payment adjustment
• Eligible for maximum positive payment adjustment

A negative payment adjustment can be avoided by reporting just a minimum amount of data!
Options for minimal “test” participation in 2017

Submit something – avoid a -4% payment adjustment with a minimum amount of data

Three options:

• Quality – report data for 1 patient for 1 quality measure (can be reported through claims),
  • Practice Tip: It is recommended that additional data (more than 1 patient) be reported for the quality category to better ensure that the penalty is avoided
• OR Improvement Activities – report 1 improvement activity (can be completed through attestation),
• OR Advancing Care Information – report 1 patient for each of the required base measures (4 or 5 based on 2014 or 2015 certified EHR technology)

Other approaches - With both the partial (90-day) and full-year participation options, physicians are eligible to receive the maximum positive payment adjustment for reporting the full requirements for each category, if the number of cases is sufficient to be scored
MIPS Quality Category
Quality category – Individual and small group reporting

60% of MIPS final score in 2017
Total possible points = 10 x # of measures reported (e.g., 60 points for 6 measures)

Reporting requirements:

- Minimum of 6 individual measures, including one outcome measure (or a high-priority measure if an outcome measure is not available); or alternatively (to the 6 individual measures), report one specialty-specific measure set
- Report each measure for 50% of applicable patients
- For groups of 16 or more 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
  - Thus, if a group reports 6 individual measures and satisfies the requirements for automatic calculation of the all-cause readmission measure (if it is a group of 16 or more eligible clinicians and has at least 200 cases that are eligible for the measure), then the group’s quality score will be based on its performance in 7 measures out of a total of 70 points

Reporting Mechanisms:

- Claims, qualified clinical data registry (QCDR), qualified registry, EHR

Score:

- Physicians receive 3-10 points for each measure based on their performance compared to a benchmark. Physicians will automatically receive 3 points for submitting information on a measure
- More points with high performance compared to the benchmark
- Bonus points for reporting additional high-priority measures (not included in denominator for total points); reporting measures electronically using an EHR, registry, QCDR

Quality Score (60% of final score in 2017)
Quality category – Group Reporting Options

CMS Web Interface:

• Groups of 25 or more physicians or other eligible clinicians
• Agreeing to report all 15 Web Interface Quality Measures
• Satisfies Quality Performance Category – no additional measures required for reporting
• Complete registration process by June 30, 2017

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for MIPS

• Optional for groups of 2 or more eligible clinicians
• CAHPS Survey includes a total of 12 summary survey measures
• CAHPS Survey for MIPS only counts as 1 measure for Quality category and satisfies the high-priority measure requirement if an outcome measure is not available. Groups must still report at least 5 additional measures using another data submission method to satisfy Quality category requirements.
• Must register by June 30, 2017
Quality breakdown of “50% of applicable patients” requirement

Report each measure for 50% of applicable patients

“Applicable patients” means the total number of patients who meet the denominator criteria specified by CMS for each measure.

“50% of applicable patients” means that, out of all the patients who met the denominator criteria, the measure is reported for at least 50% of those patients.

- E.g., 100 patients meet the denominator criteria for the tobacco use screening and cessation intervention measure. The “50% of applicable patients” requirement would be met if some data related to the measure is then reported for at least 50 of those 100 patients, including whether you conducted the quality activity related to the measure or not. For example, the threshold would be met if you reported that you conducted a screening and cessation intervention for 24 patients and did not conduct a screening and/or cessation for the other 26 patients (24 patient + 26 patients = 50 patients).

Do only Medicare Part B patients count towards “applicable patients” or does this include all patients from all payers?

- This depends on the reporting mechanism:
  - Claims – Medicare Part B patients
  - CAHPS as part of CMS Web Interface – Medicare Part B patients
  - QCDR, qualified registry, and EHR – Patients from all payers, including Medicare (all-payer mix)
How is the “50% of applicable patients” different than the performance score?

The “50% of applicable patients” is the data completeness criteria, which must be satisfied for you to receive a performance score. The performance score is how often you completed/conducted the required quality improvement activity related to each measure.

How is the performance score determined?

• The performance score for each measure is determined by looking at the number of patients that meet the denominator criteria for whom the measure is reported and who are not excluded, and seeing for how many of those patients you performed a quality activity that could satisfy the measure (the numerator for the measure)
  • Some patients may meet the denominator criteria but may ultimately be excluded from the denominator due to the measure specifications (note: while these excluded patients would count toward the data completeness criteria, they do not count toward the performance score criteria)
  • Some measures may have more than one quality activity that can satisfy the measure, these are denoted as “performance met” activities in the CMS measures specification documents
• Your numerator/denominator performance will then be compared to the benchmark for the measure, and you will receive points for that measure based on how you performed in relation to the benchmark
  • Benchmarks for the measures have been determined using previous years’ data
  • As noted in the previous slide, you will receive a minimum of 3 points for submitting data as part of the 2017 reporting year, regardless of your actual performance in relation to the benchmark
  • For measures without a benchmark (new measures or measures without sufficient data to establish a benchmark) you will receive 3 points for the 2017 reporting year
  • Lastly, topped out measures – generally, those measures in which all physicians perform extremely well (e.g., median performance is 95% or higher) – will be scored differently beginning the second year the measure is identified as topped out. This means that they will not be scored differently for the 2017 reporting year, but will be scored differently beginning with the 2018 reporting year
Quality category individual measures

• There are 271 MIPS individual measures (across all specialties and settings) available for 2017 reporting

• Physicians can use the CMS measures search tool to help filter the list down to applicable measures

• MIPS measures and the measures search tool are available on CMS’s Quality Payment Program website: https://qpp.cms.gov/measures/quality

• There are more measures to come that will be reportable through QCDRs that are not included as part of CMS’s MIPS measures list
  • Reminder: QCDRs could be specialty-, condition-, treatment-specific, etc.
  • Each QCDR will offer up to 30 measures (non-MIPS measures), in addition to the MIPS measures, and these may be more applicable and meaningful for physicians
  • A full list of QCDRs and their measures will be available this spring

• Alternatively, clinicians can report one of 30 specialty-specific measures sets (next slide)
Quality category specialty-specific measure sets

• There are 30 specialty measure sets available for 2017 reporting
• Some measure sets contain less than 6 measures, in this case you are only required to report on only those measures that are applicable
  • *E.g.*, A measures set has 5 measures, and only 3 of those 5 measures are applicable to your practice, you are only required to report those 3 measures
• Some measure sets contain more than 6 measures, in this case you are only required to report on 6 measures (one of which must be an outcome or high-priority measure – all measure sets include at least one outcome or high priority measure)

<table>
<thead>
<tr>
<th>Allergy/Immunology</th>
<th>Emergency Medicine</th>
<th>Internal Medicine</th>
<th>Orthopedic Surgery</th>
<th>Preventive Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>Gastroenterology</td>
<td>Interventional Radiology</td>
<td>Otolaryngology</td>
<td>Radiation Oncology</td>
</tr>
<tr>
<td>Cardiology</td>
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<td>Mental/Behavioral Health</td>
<td>Pathology</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>Dermatology</td>
<td>General Practice</td>
<td>Neurology</td>
<td>Pediatrics</td>
<td>Thoracic Surgery</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>General Surgery</td>
<td>Obstetrics/Gynecology</td>
<td>Physical Medicine</td>
<td>Urology</td>
</tr>
<tr>
<td>Electrophysiology Cardiac Specialist</td>
<td>Hospitalists</td>
<td>Ophthalmology</td>
<td>Plastic Surgery</td>
<td>Vascular Surgery</td>
</tr>
</tbody>
</table>
CMS measures search tool . . .

- MIPS measures and the measures search tool are available on CMS’s Quality Payment Program website: https://qpp.cms.gov/measures/quality
- Option 1: determine if a specialty measure set is available
  - If a measure set is available, review the measures and determine applicability to your practice
  - If less than 6 measures, report all applicable measures
  - If more than 6 measures, select at least 6 measures and one of which is at least an outcomes measure (or high priority if an outcome measure is not available in the measure set)
- Option 2: search by the data submission method available and most convenient for your practice (claims, EHR, registry, etc.)
- Option 3: search by a key-term applicable to your specialty/practice
  - e.g., condition, diagnosis, treatment, etc.

**Select Measures**

![Select Measures Image]

Note: This measures tool will help filter and narrow down the measures, but you will need to review the CMS specifications for each measure to determine the numerator and denominator criteria. These are available on at https://qpp.cms.gov/resources/education, as a zip file labeled “Quality Measures Specifications”
MIPS Cost Category
Cost category

• In 2017 – weight of category reduced to zero percent of final score
• 2018 – category will be 10% of final score

Reporting requirements and mechanisms:
• No data is submitted on specific measures
• CMS uses administrative claims data to assess performance

Measures:
• New cost measures are being developed
• Possible measures:
  • Medicare spending per beneficiary
  • Total per capita cost
  • Episode based measures
  • Patient condition groups and patient relationship codes

Score:
• CMS will use administrative claims data to calculate 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
### Performance to payment timeline – submission and CMS dates for 2017 performance year

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan. 1, 2017</td>
<td>Performance period began</td>
</tr>
<tr>
<td>March/Spring 2017</td>
<td>Registration deadline for CMS Web Interface and CAHPS</td>
</tr>
<tr>
<td>June 30, 2017</td>
<td>CMS review of APM Participation List</td>
</tr>
<tr>
<td>Aug. 31, 2017</td>
<td>Last day to begin 90-day reporting period</td>
</tr>
<tr>
<td>Oct. 2, 2017</td>
<td>CMS review of APM Participation List</td>
</tr>
<tr>
<td>Dec. 31, 2017</td>
<td>Last day 2017 claims processed for 2019 adjustment</td>
</tr>
<tr>
<td>Late Feb. 2018</td>
<td>CMS review of APM Participation List</td>
</tr>
<tr>
<td>March 31, 2018</td>
<td>Register claims processed for 2019 adjustment</td>
</tr>
<tr>
<td>Fall 2018</td>
<td>CMS feedback reports on 2017 performance and targeted review period to appeal errors</td>
</tr>
<tr>
<td>Jan. 2019</td>
<td>2017 data submission deadline for QCDRs, qualified registries, EHRs, CMS Web Interface, attestation</td>
</tr>
<tr>
<td></td>
<td>CMS applies adjustment based on 2017 performance</td>
</tr>
</tbody>
</table>
Next steps and looking forward
Next Steps: Should I select the MIPS pathway?

1. Determine whether you are exempt from MIPS participation
2. Pick your quality reporting pace for 2017 by evaluating practice readiness
3. Select the best reporting mechanism(s) by evaluating practice resources
   - Is a specialty-, diagnosis-, or treatment-specific QCDR with more applicable measures available?
   - What new processes and workflows will need to be put in place to meet the reporting requirements?
   - Do you have access to an EHR?
4. Consider whether the Advanced APM option is feasible before making the final decision

If you aren’t participating in an Advanced APM:
   - Review the quality category measures and improvement activities and select at least one measure or activity to avoid the negative payment adjustment
   - Determine if participating for a minimum of 90 days and becoming eligible to receive a positive payment adjustment is feasible for you/your practice
   - Review current 2017 and proposed 2018 Advanced APMs and determine if participating in the APM track is an option for the future

If you are participating in an Advanced APM:
   - CMS will make 3 evaluations in 2017 to determine whether physicians meet QP/PQ thresholds
     - The determination periods are March 31 (decision by July 2017), June 30 (decision by October 31), and August 31 (decision by December 31)
     - Check these determinations to see if you have meet the QP/PQ thresholds and are exempt from MIPS
What PAI-Healthsperien resources will be available to help?

- **Follow-on products in early 2017** – In-depth one-pagers and monographs focused on topics such as the MIPS scoring system and strategies for reporting and how to meet the minimum reporting requirements for 2017

- **In development** – Guide to additional resources in physician communities

- **FAQ document** – updated on a continuous and ongoing basis with important questions

- **Regular e-mail updates** – Emails will provide updates on new information, materials, and tools available from PAI, Healthsperien, as well as CMS and other organizations
www.PhysiciansAdvocacyInstitute.org