Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Scoring 101 Guide for Year 2 (2018)

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How To Use This Guide

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The table of contents is interactive. You can click on a chapter to read it and then click on the chapter title to go back to the table of contents.

Hyperlinks

There are hyperlinks to the Quality Payment Program website throughout the guide that will take you to more information and resources.

Resources

There are icons in the guide so you'll know that there are more resources on the topic you're reading about.

We developed this guide to provide a general summary about MIPS scoring. **Please note that this guide does not address MIPS APM policies or the APM scoring standard.** Additionally, it's not intended to give rights, impose obligations or take the place of either the written law or regulations. We urge you to review the specific statutes, regulations, and other interpretive materials for their full and accurate contents.

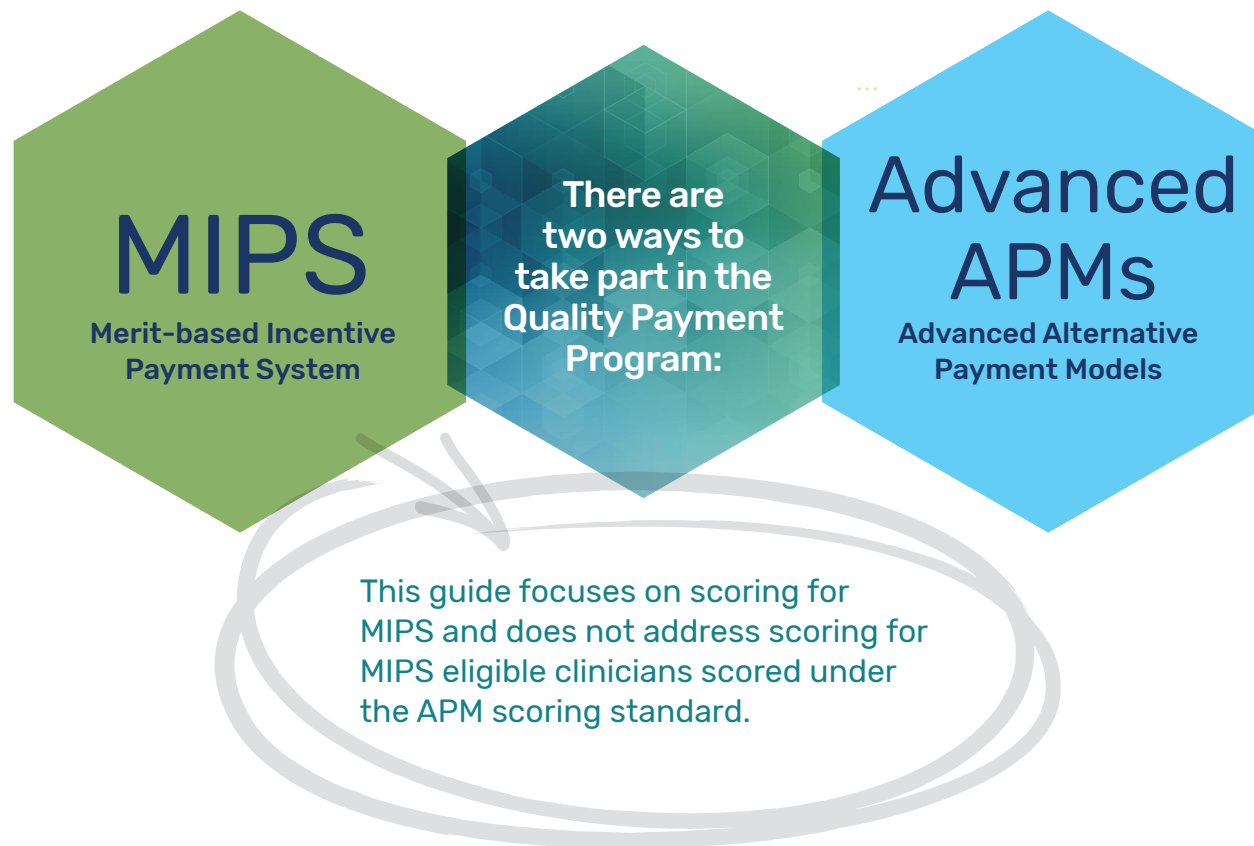In this guide, we use the term "clinician" for MIPS eligible clinicians.

DISCLAIMER: Whenever possible, we've incorporated images from the Performance Year 2017 QPP submission system to connect scoring policies with the submission experience. Keep in mind that these images may not exactly represent what you will see in the Performance Year 2018 QPP submission system.

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OVERVIEW

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What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA requires CMS, by law, to implement an incentive program — referred to as the Quality Payment Program — which provides two participation tracks for clinicians:

MIPS
Merit-based Incentive Payment System

There are two ways to take part in the Quality Payment Program:

Advanced APMs
Advanced Alternative Payment Models

This guide focuses on scoring for MIPS and does not address scoring for MIPS eligible clinicians scored under the APM scoring standard.

What is MIPS?

Under MIPS, there are four performance categories that affect your future Medicare Physician Fee Schedule payments. Each performance category is scored by itself and has a specific weight that is part of the MIPS Final Score. The payment adjustment assessed for MIPS eligible clinicians is based on the Final Score. Generally speaking, these are the performance category weights for Year 2 (2018):

Highlights of Category in Year 2 (2018)			
Quality	**Cost**	**Improvement Activities**	**Promoting Interoperability** *(formerly Advancing Care Information)*
50% of MIPS Score	**10%** of MIPS Score	**15%** of MIPS Score	**25%** of MIPS Score
Assesses the value of care to ensure patients get the right care at the right time	Helps create efficiencies in Medicare spending No reporting/data submission requirement	Supports expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, participation in an APM, achieving health equity, emergency preparedness and response, and integrated behavioral and mental health	Supports the secure exchange of health information and the use of certified electronic health record (EHR) technology

In certain circumstances, one or more of the performance categories may be reweighted to 0%; more information on reweighting is provided in each category section. Appendix B provides an overview of the different performance category weights when one or more performance categories has been reweighted and provides additional information about the Extreme and Uncontrollable Circumstances policy which has been extended to all categories for the 2018 performance year.

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MIPS QUALITY PERFORMANCE CATEGORY

What are the Quality performance category data submission requirements?

You can select from **more than 270** available quality measures finalized for Year 2 (2018). Starting in 2018, you will need to collect and submit data for each quality measure for the entire calendar year of 2018.

To meet the Quality performance category requirements, a MIPS eligible clinician, group, or Virtual Group must:

- Submit 6 quality measures for the 12-month performance period.
  - 1 of these 6 must be an outcome measure OR another high priority measure in the absence of an applicable outcome measure.
  - The CAHPS for MIPS survey measure counts as 1 of the 6 measures for registered groups and Virtual Groups. The CAHPS for MIPS survey measure counts for a patient experience measure and can be counted as a high priority measure if there are no applicable outcome measures.

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Instead of picking 6 measures from the MIPS quality measures list, you can choose to do the following:

- Select your measures from a defined specialty measure set. One of the measures must be an outcome measure OR another high-priority measure in the absence of an applicable outcome measure. If the specialty measure set has fewer than 6 measures, you need to submit all measures within the specialty set.

- Submit all quality measures included in the CMS Web Interface, a submission mechanism available to registered groups and Virtual Groups with 25 or more eligible clinicians. The CAHPS for MIPS survey measure can be submitted as an additional high-priority measure.

- Submit 6 measures through a Qualified Clinical Data Registry (QCDR). QCDRs are not limited to MIPS measures and can use other measures approved by CMS.

The Quality performance category also includes the All-Cause Hospital Readmission measure, a measure that is evaluated by administrative claims (no additional data submission required). Groups and Virtual Groups with 16 or more eligible clinicians are subject to the All-Cause Hospital Readmission measure if they meet the case minimum of 200 patients for the measure. If the group or Virtual Group falls below the case minimum, then the All-Cause Hospital Readmission measure won't be calculated, and MIPS eligible clinicians will only be scored on the submitted measures.

Are the Quality performance category data submission requirements different for the **CMS Web Interface**?

Yes. Registered groups and Virtual Groups using the CMS Web Interface will submit data for all the required Quality measures in the CMS Web Interface for a full year, even if they are also submitting the CAHPS for MIPS measure.

Note: The CMS Web Interface shows that there are 14 measures total as opposed to 15. This is because the Diabetes Mellitus (DM) measure is a composite measure that comprises 2 measures (DM-2 and DM-7). In the CMS Web Interface, these count as one measure for scoring purposes, though you will need to meet data completeness requirements for both measures to receive a score.

Submitting Quality Measures via Certified EHR Technology (CEHRT), Claims, Qualified Clinical Data Registry (QCDR), or Qualified Registry

How are measures assessed in the Quality performance category for Year 2 (2018)?

When you submit measures for the MIPS Quality performance category, your performance on each measure is assessed against a benchmark to see how many points you earn for the measure.

The 2018 Quality benchmarks are differentiated by submission mechanism, which means there are benchmarks for each of the following submission mechanisms:

- EHR
- QCDR /Qualified Registry
- Claims

SUBMITTING QUALITY MEASURES VIA CEHRT, CLAIMS, QCDR, OR QUALIFIED REGISTRY

Historical benchmarks for each of these submission mechanisms are based on the actual Physician Quality Reporting System (PQRS) performance data submitted in 2016. Due to revisions in the 2018 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey, benchmarks for CAHPS will be calculated based on 2018 performance data and will be available for each summary survey measure (SSM).

The historical benchmarks for 2018 Quality measures were reliably established by meeting the following criteria:

- The measure was available in 2016 and its specifications are similar to the 2018 measure,
- 20 or more individuals or groups submitted the measure through the same mechanism where the measure:
  - Met or exceeded the minimum case volume of 20 eligible cases (has enough data for it to be reliably measured);
  - Met or exceeded the 60% data completeness criteria; and
  - Had performance greater than 0 % (or less than 100% for inverse measures).

The data submitted by all individuals and groups, regardless of specialty or practice size, is used to develop the benchmarks for each submission mechanism.

What if a quality measure doesn't have a historical benchmark?

For a measure without a historical benchmark, we will try to calculate a benchmark following the submission period based on 2018 performance data on those measures.

Performance period benchmarks can be calculated when:

- 20 or more individuals, groups or Virtual Groups submit the measure through the same mechanism where the measure:
  - Meets or exceeds the minimum case volume of 20 eligible cases (has enough data for it to be reliably measured);
  - Meets or exceeds the 60% data completeness criteria; and
  - Has a performance rate greater than 0% (or less than 100% for inverse measures).

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How are measures scored?

If a measure can be reliably scored against a benchmark, it means:

- A benchmark is available; and
- The volume of cases you've submitted is sufficient (> 20 cases for most measures; >200 cases for readmission measure); and
- You've met data completeness requirements (submitted data for at least 60% of the denominator eligible patients/instances).

Measure Achievement Points

Measure achievement points are earned based on a measure's performance in comparison to a benchmark, exclusive of bonus points.

- You will continue to receive between 3 and 10 achievement points for quality measures that can be reliably scored against a benchmark.
- You will continue to earn 3 points for quality measures that meet data completeness requirements but do not have a benchmark or meet the case minimum.
- Beginning in 2018, you will earn 1 point for quality measures that do not meet the data completeness requirements (generally 60% for 2018).

However, small practices will continue to earn 3 points for quality measures that don't meet data completeness requirements.
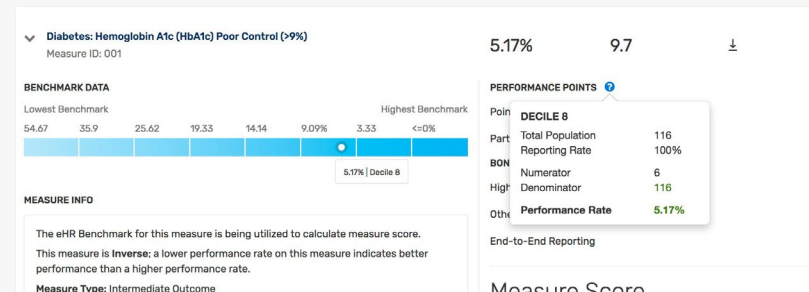
Exception: *There are 6 specified, topped out measures that are capped at 7 points. These measures are identified in the 2018 Quality Benchmarks document and Quality Performance Category Fact Sheet.*

If you don't submit at least one available measure, you will receive 0 points in this category.

Exception: *Groups and virtual groups that are evaluated on the All-Cause Hospital Readmission measure will receive a Quality score based on their performance on that measure.*

SUBMITTING QUALITY MEASURES VIA CEHRT, CLAIMS, QCDR, OR QUALIFIED REGISTRY

Measure Bonus Points

Measure bonus points are earned for submitted measures in addition to achievement points.

You can earn bonus points if you:

- Submit additional outcome, patient experience or other high-priority measures beyond the one required.

  ○ 2 bonus points for each additional outcome and patient experience measure that meet case minimum and data completeness requirements and have a performance rate >0%.

  ○ 1 bonus point each for other high-priority measures that meet case minimum and data completeness requirements and have a performance rate >0%.

> **Note:**
> - *These bonus points are capped at 10% of the Quality performance category denominator (or the total number of available measure achievement points). This cap is separate from the cap on bonus points earned for end-to-end electronic reporting.*
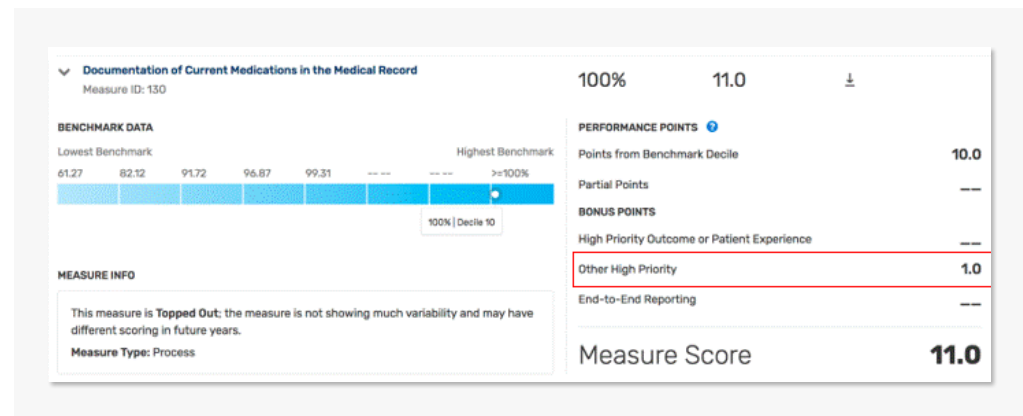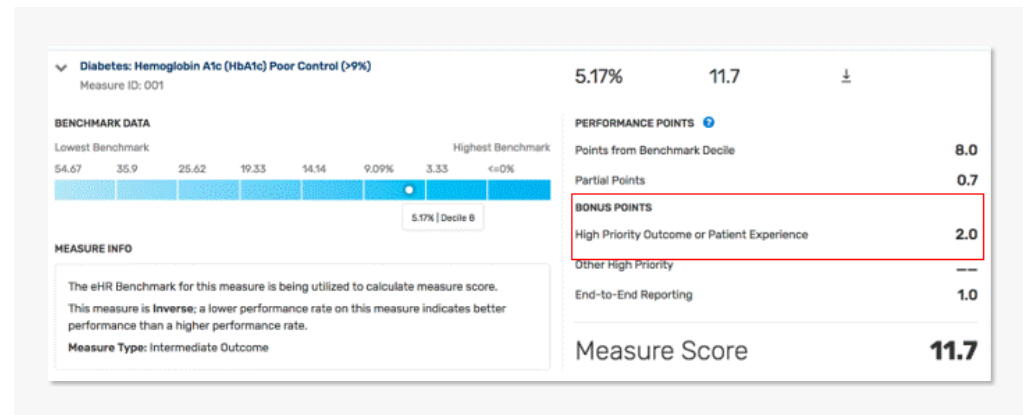
SUBMITTING QUALITY MEASURES VIA CEHRT, CLAIMS, QCDR, OR QUALIFIED REGISTRY

Measure Bonus Points (continued)

You earn bonus points if you:

- Use Certified EHR Technology (CEHRT) and meet end-to-end electronic reporting requirements.

  ○ **1 bonus point** for each measure that meets end-to-end electronic reporting criteria (don't need to meet case minimum or data completeness requirements).
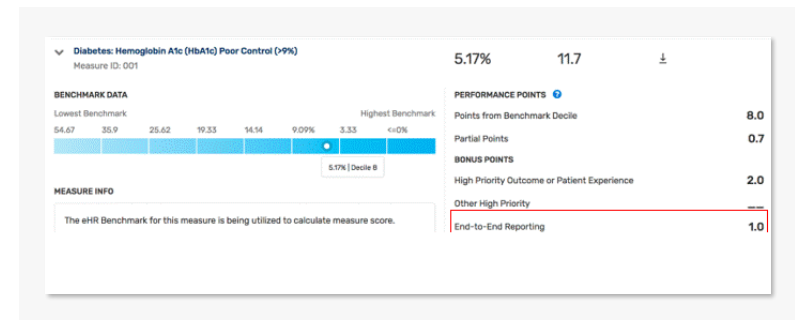
Note:

- *These bonus points are capped at 10% of the Quality performance category denominator (or the total number of available measure achievement points). This cap is separate from the cap on bonus points for submitting an additional outcome or other high priority measure.*
- *Measures submitted by a Qualified Registry or QCDR and identified in the submission as meeting end-to-end electronic reporting criteria are scored against the EHR benchmark.*
- *The bonus points are not applicable to claims submissions.*

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SUBMITTING QUALITY MEASURES VIA CEHRT, CLAIMS, QCDR, OR QUALIFIED REGISTRY

What if I submit more than 6 measures?

If you submit more than 6 measures through a single submission mechanism, then only 6 of those measures will contribute measure achievement points to your Quality performance category score. However, we will include any bonus points from the remaining measures, as long as you haven't exceeded the 10% cap. Each type of bonus is capped at 10%.

When determining which measures are included in the top 6, we select an outcome measure (if not available, a high-priority measure in its place) and the next five highest scoring measures, not necessarily those with the highest performance rate.

- If you submit more than 6 quality measures through a single submission method (e.g. Claims or EHR), then we will include the highest scoring outcome measure, plus the next 5 highest scoring measures reported through that method.

- If you don't have an outcome measure available, then we will include the highest scoring high priority measure, plus the next 5 highest-scoring measures.

- If you don't submit an outcome or high priority measure, we will only score the top 5 measures and you will receive a score of 0/10 for the missing outcome or high priority measure.

> Remember that scoring is determined by comparing the performance rate to the measure's benchmark. If you submit two measures, each with an 85% performance rate, one may earn 7 points while the other earns 10 points, based on the benchmarks for each measure.

SUBMITTING QUALITY MEASURES VIA CEHRT, CLAIMS, QCDR, OR QUALIFIED REGISTRY

How many measure achievement points can I earn in the Quality performance category?

Clinicians, groups and Virtual Groups who are not scored on the All-Cause Hospital Readmission measure can earn a maximum of 60 measure achievement points in the Quality performance category.

Groups and Virtual Groups who are scored on the All-Cause Hospital Readmission Measure can earn a maximum of 70 measure achievement points in the Quality performance category.

Can the denominator (maximum number of points) be lower than 60 points?

Yes, your denominator may be lowered if:

- You submit a specialty measure set that has fewer than 6 measures; or

- You don't have 6 measures that apply to you and you submit your measures via claims or a Qualified Registry.

If you submit a complete specialty measure set that has less than 6 measures, then we'll lower the denominator (maximum number of points) by 10 points for each measure that isn't available.

If you submit fewer than 6 measures via claims or a Qualified Registry, then we'll determine whether additional measures were available by comparing the measures you submitted with a predefined list of clinically related measures. Then we will lower the denominator by 10 points for each measure that isn't available. (This is known as the Eligible Measure Applicability [EMA] process.)

Note: *If we see that you could have submitted additional clinically related measures and you didn't submit those measures, then we won't remove those measures from the maximum number of points available for the Quality performance category. Failure to submit the measures under the Quality performance category will result in a score of 0 out of 10 for each of these measures.*

SUBMITTING QUALITY MEASURES VIA CMS WEB INTERFACE

How are measures assessed in the Quality performance category for Year 2 (2018)?

When you submit measures through the CMS Web Interface, your performance on each measure is assessed against a benchmark to see how many points you earn for the measure. Groups and Virtual Groups submitting their quality measures through the CMS Web Interface will be assessed against benchmarks from the Medicare Shared Savings Program.

What if a CMS Web Interface measure doesn't have a benchmark?

Unlike other submission mechanisms, we will not attempt to calculate a performance period benchmark if there isn't an existing benchmark. Measures without an existing benchmark do not count toward your Quality performance category score, as long as data completeness requirements are met.

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SUBMITTING QUALITY MEASURES VIA CMS WEB INTERFACE

How are CMS Web Interface measures scored?

Measure Achievement Points

Measure achievement points are based on your performance on a measure in comparison to a benchmark, exclusive of bonus points.

- You will continue to receive between 3 and 10 points achievement points for Quality measures that meet case minimum and data completeness requirements, and that can be scored against a benchmark.

- You will receive 0 points (0 out of 10) for measures that are not submitted.

- You will continue to receive 0 points (0 out of 10) for measures that do not meet data completeness requirements.

- CMS Web Interface measures with fewer than 20 beneficiaries in the sample will not be scored and will be excluded from the quality denominator as long as data completeness requirements are met.

- CMS Web Interface measures without an existing benchmark will not be scored and will be excluded from the quality denominator as long as data completeness requirements are met.

If you don't submit at least 1 measure that meets data completeness requirements, you will receive 0 points in this category.

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How are CMS Web Interface measures scored?, *continued*

Measure Bonus Points

You can earn bonus points if you:

● Submit the additional outcome and high-priority measures required by the CMS Web Interface.

  ○ 2 bonus points for the additional outcome measure and for each patient experience measure, including CAHPS for MIPS survey, that meet case minimum and data completeness requirements.

  ○ 1 bonus point for each additional high-priority measure that meets case minimum and data completeness requirements.

  Note: *These bonus points are capped at 10% of the Quality performance category denominator (or the total number available measure achievement points).*

● Submit your measures according to end-to-end electronic reporting criteria.

  ○ 1 bonus point for each measure that meets end-to-end electronic reporting criteria.

  Note: *These bonus points are capped at 10% of the Quality performance category denominator (or the total available measure achievement points).*

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How many measure points can I earn in the Quality performance category?

Groups and Virtual Groups submitting through the CMS Web Interface who are not scored on the All-Cause Hospital Readmission Measure and did not administer the CAHPS for MIPS survey can earn a maximum of 110 measure achievement points in the Quality performance category.

Groups and Virtual Groups submitting through the CMS Web Interface who are EITHER scored on the All-Cause Hospital Readmission Measure OR administer the CAHPS for MIPS survey can earn a maximum of 120 measure achievement points in the Quality performance category.

Groups and Virtual Groups submitting through the CMS Web Interface who are scored on BOTH the All-Cause Hospital Readmission Measure AND the CAHPS for MIPS survey measure can earn a maximum of 130 measure achievement points in the Quality performance category.

Can the denominator (maximum number of points) be lower than 110 points?

Yes, your denominator will be lowered if:

- You have fewer than 20 beneficiaries in a measure's sample (don't meet case minimum); AND

- You submit complete data for all of the beneficiaries in the sample (meet data completeness requirements).

If you meet data completeness requirements, then we'll lower the denominator (maximum number of points) by 10 points for each measure that doesn't meet case minimum.

What is Improvement Scoring?

Beginning with the 2018 performance period, MIPS eligible clinicians can earn up to 10 additional percentage points based on the rate of their improvement in the Quality performance category from the previous year. Bonus Improvement points will be incorporated into the Quality performance category score. The improvement percent score—calculated at the category level that represents improvement in achievement from one year to the next— may not total more than 10 percentage points.

Eligibility for these additional percentage points is determined by meeting the following criteria:

- Full participation in the Quality performance category for the current performance period:
  - Submits 6 measures (or a complete specialty measure set. (**Note**: 6 measures may not be applicable in some specialty sets) with at least one outcome measure;
    OR
    Submits as many measures as were available and applicable via claims or Qualified Registry;
    OR
    Submits all the measures in the CMS Web Interface.
  - All submitted measures meet data completeness requirements.
- Data sufficiency standard is met meaning there is data available and can be compared:
  - There is a Quality performance category achievement percent score (the score earned by measures based on performance excluding bonus points) for the previous performance period (transition year) and the current performance period; and
  - Data was submitted under the same identifier for the two consecutive performance periods, or CMS can compare the data submitted for the two performance periods. (See Appendix A in the Bonus Overview Factsheet for more information).

How is Improvement Scoring calculated?

Improvement scoring is calculated by comparing the Quality performance category achievement percent score (those earned by measures based on performance) from the previous period to the quality achievement percentage points in the current period. Measure bonus points are not included in Improvement Scoring.

For example, in the 2018 performance period, a MIPS eligible clinician submitted 6 measures via Certified Electronic Heath Record Technology (CEHRT). She earned 33 measure achievement points and 6 measure bonus points for end-to-end electronic reporting.

In the transition year (2017), the same MIPS eligible clinician earned 25 measure achievement points and 2 measure bonus points for reporting an additional outcome measure.

2017 Quality performance category achievement percent score	**2018** Quality performance category achievement percent score	The increase in Quality performance category achievement percent score from prior performance period to current performance period	The Improvement percent score
= **42**%	= **55**%	= **13**%	= **3.1**%
25 achievement points ÷ 60 possible points Excludes the 2 bonus points	33 achievement points ÷ 60 possible points Excludes the 6 bonus points	55% – 42%	(13% ÷ 42%) x 10%

If CMS can't compare data between two performance periods, or there is no improvement, the Improvement Score will be 0%. The improvement percent score cannot be negative.

For more information on Improvement Scoring, please review to the Bonus Overview Fact Sheet.

How is my Quality performance category percent score calculated?

Quality Performance Category Percent Score (Not to exceed 100%) **=** (**Total Measure Achievement Points** **+** **Measure Bonus Points**) / **Total Available Measure Achievement Points*** **+** **Improvement Percent Score**
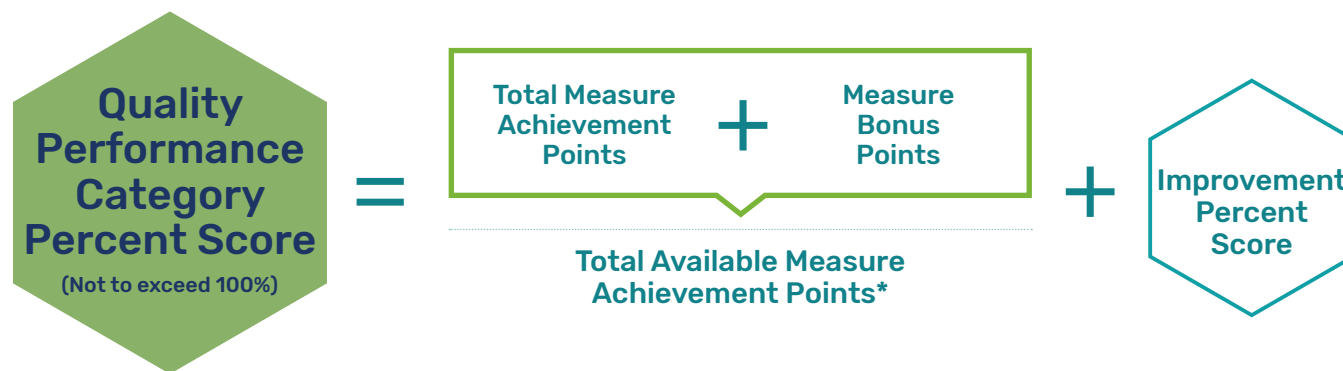
*Total Available Measure Achievement Points = the number of required measures x 10

*_High priority and end-to-end electronic reporting bonus points are each capped at 10% of the denominator, which is the total possible points you could earn in the Quality performance category. If your total possible points in Quality is set at 60, then you can earn up to 12 bonus points total, 6 points from each bonus point category._

Your Quality performance category percent score is then multiplied by the 50% Quality performance category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS final score.

The maximum score is 100% of the category weight.

Let's continue our previous example:

The MIPS eligible clinician submitted 6 measures for the 2018 performance year via Certified Electronic Heath Record Technology (CEHRT). She earned 33 measure achievement points and 6 measure bonus points for end-to-end electronic reporting. As previously determined, her Improvement percent score is 3.1%.

Category Score

$$\frac{33 \text{ Achievement Points} + 6 \text{ Bonus Points}}{60 \text{ Total Available Achievement Points}} = 65\%$$

$$65\% \text{ For Submitted Measures} + 3.1\% \text{ Improvement Percent Score} = 68.1\%$$

68.1% Quality Performance Category Percent Score $\times$ 50% Quality Category

= Contribution to Final Score
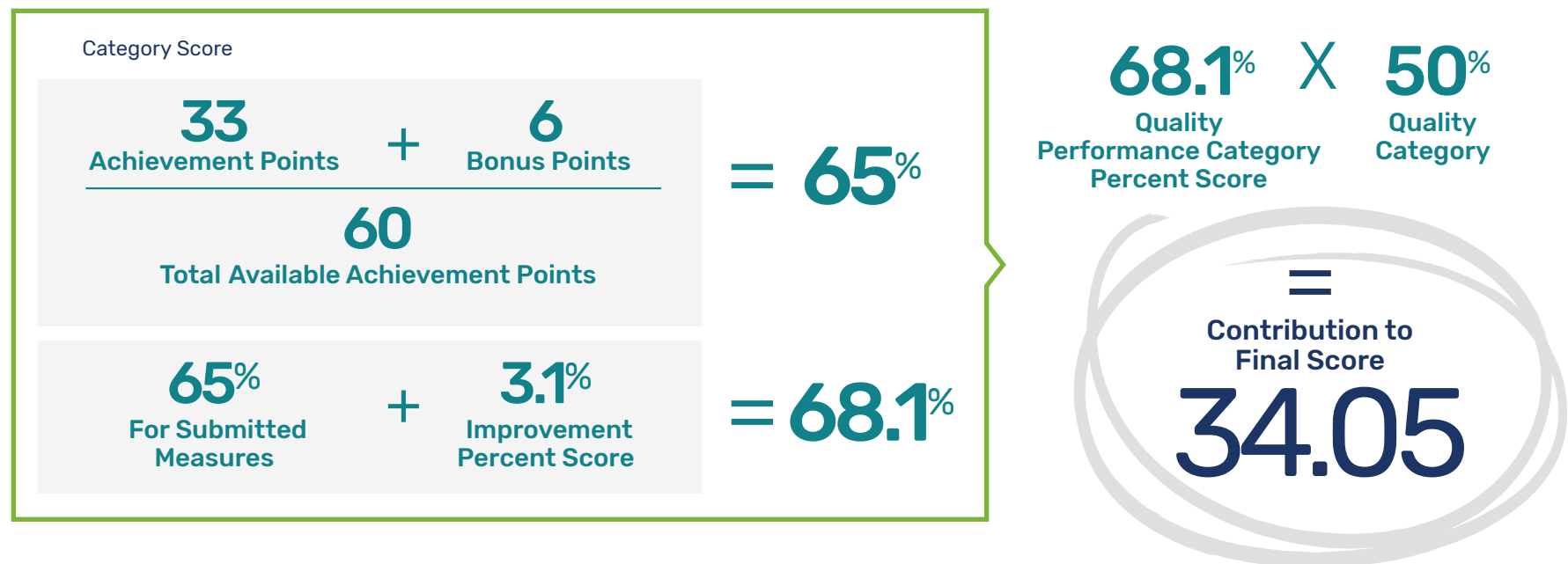
34.05

The Quality performance category percent score (68.1) is then multiplied by the weight of the Quality category (50%) to determine the number of points contributing to the final score (34.05).

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Can the Quality performance category be reweighted?

In the rare instance when there are no quality measures available to you, you won't earn any points in this category; the Improvement Activities and Promoting Interoperability (formerly Advancing Care Information) performance categories would each be reweighted to 45%, with the Cost category retaining its 10% weight. We anticipate that reweighting of the Quality performance category would be rare because there are quality measures applicable and available for most clinicians.

Please contact the Quality Payment Program if you believe this applies to you so that we can evaluate whether you have available quality measures to submit. You can contact the Quality Payment Program by phone (1-866-288-8292, TTY: 1-877-715-6222) or email (qpp@cms.hhs.gov).

We have extended our extreme and uncontrollable circumstance policy to the Quality, Cost, and Improvement Activities performance categories beginning with the 2018 performance year. Please refer to Appendix B for more information on category reweighting, including the extreme and uncontrollable circumstances policy.

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What are the steps to score quality measures submitted via Claims, CEHRT, QCDR or Qualified Registry?

For each measure submitted:

1 Check to see if data completeness requirements are met.

a. **If Yes** – continue to step 2
b. **If No** – assign 3 points to measures submitted by a small practice, or 1 point to all others

2 Check to see if case minimum requirements were met.

a. **If Yes** – continue to step 3
b. **If No** – assign 3 points

3 Check to see if there is a historical benchmark associated with the submission mechanism.

a. **If Yes** – continue to step 4
b. **If No** – assign 3 points

4 Assign achievement points based on the benchmark. Achievement points are calculated by mapping the performance rate to the benchmark by the submission type.

a. Determine the decile that the performance rate falls in and assign points

5 Calculate and add any bonus points.

a. The measure(s) doesn't/don't have to be in the "top 6" to earn bonus points

b. The high-priority/outcome bonus measure(s) has/have to meet the case minimum and data completeness requirements and have a performance rate >0%

c. The end-to-end bonus does not have to meet the cases minimum and data completeness requirements

d. Each category of bonus points (high-priority and end-to-end) is capped at 10% of the denominator of the Quality performance category score

REPEAT STEPS 1 – 5 FOR EACH SUBMITTED MEASURE

Pick the top 6 measures, including 1 outcome measure (or, if no outcome measure applies a high-priority measure), based on the highest number of achievement points for each measure. If no applicable outcome or high-priority measure is submitted, only 5 measures will be scored.
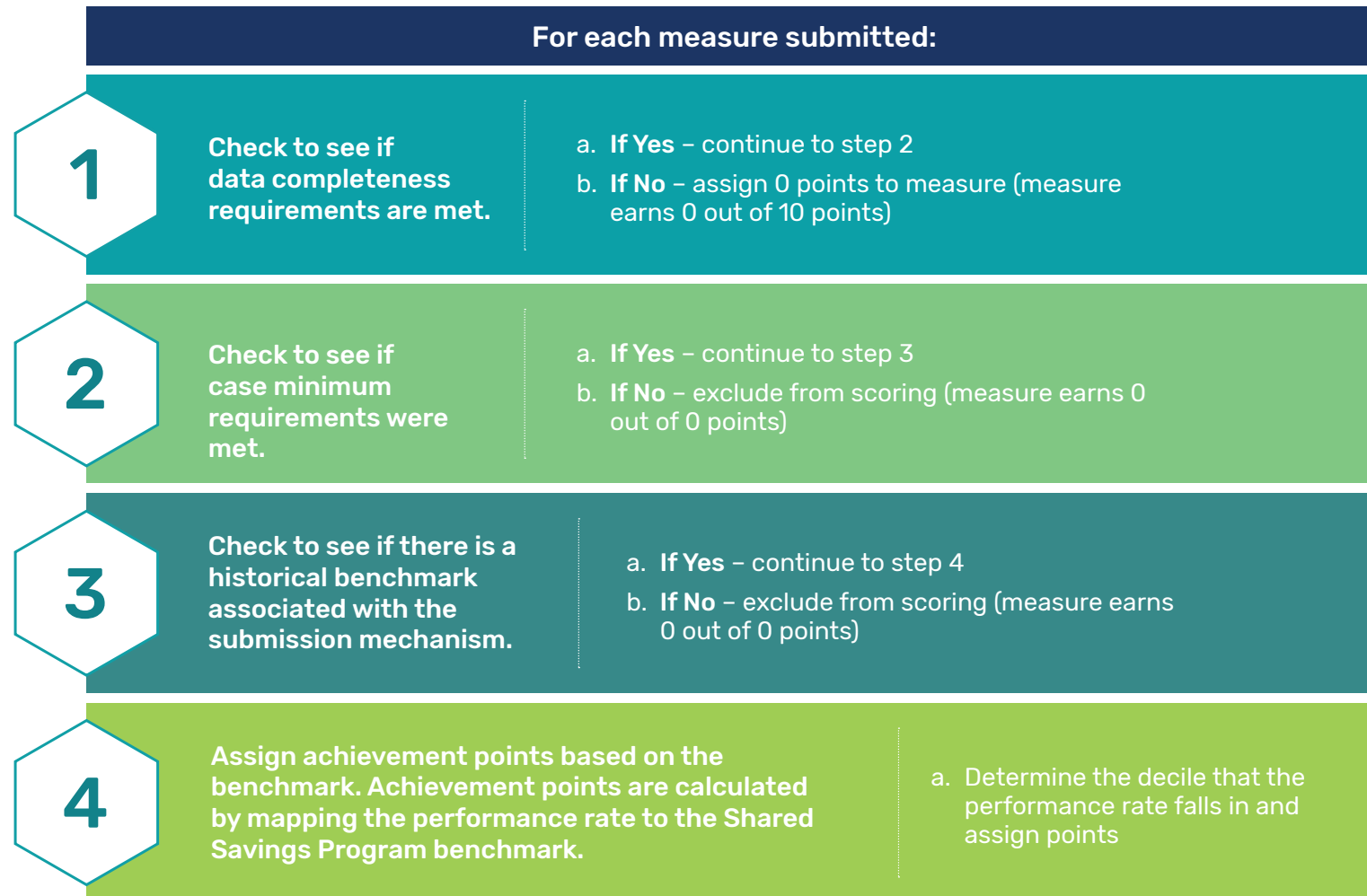
Appendix A gives you an example of how to find a benchmark, determine achievement points, and pick the top 6 measures based on the number of points.

6 Calculate the Quality performance category percent score, from 0-100%, and then figure the points that contribute to the final score.

- Quality performance category percent score = [[(Quality measure achievement points earned + total bonus points) ÷ total possible Quality measure achievement points] + Improvement Scoring]

- High-priority and end-to-end electronic reporting bonus points each can only be 10% of the denominator (total possible points the MIPS eligible clinician could receive in the Quality performance category)

- Points contributing to the final score = Quality performance category percent score X Category weight
  - This number will be rounded to the hundredth decimal place

- The total category percent score can't exceed 100%

What are the steps to score quality measures submitted via CMS Web Interface?

For each measure submitted:

1 Check to see if data completeness requirements are met.

   a. **If Yes** – continue to step 2

   b. **If No** – assign 0 points to measure (measure earns 0 out of 10 points)

2 Check to see if case minimum requirements were met.

   a. **If Yes** – continue to step 3

   b. **If No** – exclude from scoring (measure earns 0 out of 0 points)

3 Check to see if there is a historical benchmark associated with the submission mechanism.

   a. **If Yes** – continue to step 4

   b. **If No** – exclude from scoring (measure earns 0 out of 0 points)

4 Assign achievement points based on the benchmark. Achievement points are calculated by mapping the performance rate to the Shared Savings Program benchmark.

   a. Determine the decile that the performance rate falls in and assign points

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Calculate and add any bonus points.

a. The measure must meet the case minimum and data completeness requirements and have a performance rate >0%

b. Each category of bonus points (high-priority and end-to-end) is capped at 10% of the denominator of the Quality performance category score

REPEAT STEPS 1 – 5 FOR EACH SUBMITTED MEASURE

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Calculate the Quality performance category percent score, from 0-100%, and then figure the points that contribute to the final score.

- Quality performance category percent score = [[(Quality measure achievement points earned + total bonus points) ÷ total possible Quality measure achievement points] + Improvement Scoring]

- High-priority and end-to-end electronic reporting bonus points each can only be 10% of the denominator (total possible points the MIPS eligible clinician could receive in the Quality performance category)

- Points contributing to the final score = Quality performance category percent score X Category weight
  ○ This number will be rounded to the hundredth decimal place

- The total category percent score can't exceed 100%.

MIPS COST PERFORMANCE CATEGORY

How much is the Cost performance category worth?

The Cost performance category accounts for 10% of your MIPS final score for Year 2 (2018). CMS uses Medicare claims data to calculate cost measure performance, so you don't have to report data or take any additional action (other than performing your normal billing practices for Medicare claims) for this performance category.

What cost measures are used to evaluate performance?

In Year 2 (2018), two cost measures are used to determine your Cost performance category score. The measures are:

1. Medicare Spending Per Beneficiary (MSPB)

   - The MSPB measure assesses total costs to Medicare incurred by a single beneficiary during a qualifying inpatient hospital stay or "MSPB episode." An MSPB episode includes all Medicare Parts A and B claims with start dates within the episode window, which is the period of time beginning three days prior to a beneficiary's hospital index admission through 30 days after the beneficiary is discharged.

   - Using Medicare Parts A and B claims data, with certain exclusions attached, the MSPB measure compares observed episode costs to expected episode costs. Expected costs of an episode are based on the clinical condition or procedure that triggers the episode along with other factors that may influence cost but are not directly related to patient care. An overview of the MSPB measure calculation is described in bullet points below:

      ○ The numerator for the measure is the sum of the ratios of payment-standardized observed to expected MSPB measure episode costs for all MSPB episodes attributed to the TIN-NPI or TIN, depending on the chosen reporting level. The sum of the ratios is then multiplied by the national average payment-standardized observed episode cost to convert the ratio to a dollar amount.

      ○ The denominator for the MSPB measure is the total number of MSPB measure episodes attributed to the TIN-NPI or TIN, depending on the chosen reporting level.

   - Minimum case volume: 35

continued

2. Total Per Capita Costs for All Attributed Beneficiaries (TPCC)

- Using claims data, the TPCC measure assesses all Medicare Parts A and B costs incurred by a beneficiary during the 12-month performance period by calculating the risk-adjusted per capita costs incurred by beneficiaries attributed to an individual clinician, as identified by a unique TIN-NPI. The TPCC measure is a payment-standardized, annualized, risk-adjusted, and specialty-adjusted measure that can be reported at the TIN or the TIN-NPI level, depending on the method of MIPS participation, also referred to as the chosen reporting level. For individual clinicians participating in MIPS as individuals, the TPCC measure will be reported at the TIN-NPI level. For groups of clinicians, identified by a TIN, that participate in MIPS as groups, measure performance will be reported at the TIN level.

- An overview of the TPCC measure calculation is described in bullet points below:

  ○ The numerator of the measure is the sum of the annualized, risk-adjusted, specialty-adjusted Medicare Parts A and Part B costs incurred across all beneficiaries attributed to an individual TIN-NPI or to all individual clinicians under a TIN (depending on the level of MIPS reporting).

  ○ The denominator for the measure is the number of all Medicare beneficiaries who received Medicare-covered services and are attributed to an individual TIN-NPI or to all TIN-NPIs under a TIN (depending on the level of MIPS reporting), during the performance period.

- Minimum case volume: 20

For more detailed information about the methodology used to calculate the MSPB and TPCC measures, please refer to the specific [Measure Information Form (MIF)](.).

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How is the Cost performance category scored?

For a cost measure to be scored, an individual MIPS eligible clinician, group or Virtual Group must meet or exceed the case minimum for that cost measure.

To determine your Cost performance category score, CMS will:

1. Establish a single, national benchmark for each cost measure based on the performance period, not a historical baseline period;

2. Compare performance on each measure (expressed as a dollar amount) to the performance period benchmark(s); and

3. Assign 1 to 10 achievement points to each scored measure based on that comparison. The amount of achievement points assigned to each measure is determined by identifying which benchmark decile range the individual, group or Virtual Group's measure performance falls in between.

Note: The Cost performance category score is the equally-weighted average of all scored measures. If only one measure can be scored, then that measure's score will serve as the performance category score. If no cost measures can be scored, then CMS will reweight the Cost performance category weight to the Quality performance category, making the Quality performance category worth 60% of your 2018 final score.

$$\text{Cost Performance Score} = \frac{\text{Total Points Assigned Each Scored Measure}}{\text{Total Possible Points Available}}$$

Example:

A MIPS eligible clinician is only scored on the TPCC measure. When compared to the performance year benchmark, she earns 4.6 points.

Her Cost performance category percent score will be 46% (4.6/10).

The following figures show different examples of Cost performance category scoring. These are just EXAMPLES for illustrative purposes only.

Reporting Level: Group/Virtual Group			
Condition:	**Scenario 1**	**Scenario 2**	**Scenario 3**
# of MSPB episodes attributed across all individual clinicians (identified by TIN-NPI) who assigned their billing rights to the TIN of the group participating in MIPS as a group	54	245	14
MSPB measure scored for the group?	Yes	Yes	No
# of TPCC beneficiaries attributed across all individual clinicians (identified by TIN-NPI) in the group (identified by TIN) who have assigned their billing rights to the group's TIN, based on primary care services received by the beneficiaries during the performance period	18	23	6
TPCC measure scored for the group?	No– the group did not meet the minimum case volume for the measure	Yes	No
# of cost measures scored	1	2	0
# of total possible cost achievement points available based on the # of cost measures scored	10	20	0

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Reporting Level: Group/Virtual Group, *continued*

Condition:	Scenario 1	Scenario 2	Scenario 3
Points assigned to the MSPB measure, based on performance compared to single, national benchmark	**6.5**	**6.4**	**N/A- not scored**
Points assigned to the TPCC measure (based on performance compared to single, national benchmark)	**N/A- not scored**	**9.1**	**N/A- not scored**
Cost performance category weight	**10**%	**10**%	0%- the Quality performance category is reweighted to 60% of the group's 2018 MIPS total score
Cost performance category percent score	6.5/10= 0.65 x 100= 65%	6.4+9.1=15.5 / 20=0.775 x 100= 77.5% Mathematically equivalent to [(6.4/10) + (9.1/10)] / 2 = 0.775 X 100= 77.5%	**N/A**

Reporting Level: Individual

Condition:	Scenario 1	Scenario 2	Scenario 3
# of MSPB episodes attributed to the individual clinician's TIN-NPI	**34**	**60**	**36**
MSPB measure scored for the individual?	**No**	**Yes**	**No**

Reporting Level: Individual, *continued*			
Condition:	**Scenario 1**	**Scenario 2**	**Scenario 3**
# of TPCC beneficiaries attributed to the individual clinician's TIN-NPI based on primary care services received by beneficiaries during the performance period	**29**	**90**	**11**
TPCC measure scored for the individual?	**Yes**	**Yes**	**No**
# of Cost measures scored	**1**	**2**	**0**
# of total possible Cost achievement points available based on the # of Cost measures scored	**10**	**20**	**0**
Points assigned to the MSPB measure, based on performance compared to single, national benchmark	**N/A- not scored**	**4.4**	**N/A- not scored**
Points assigned to the TPCC measure (based on performance compared to single, national benchmark)	**3.6**	**4.8**	**N/A- not scored**
Cost performance category weight	**10**%	**10**%	0%- the Quality performance category is reweighted to 60% of the individual MIPS eligible clinician's 2018 MIPS Final Score
Cost performance category percent score	**36**% (3.6/10)X100=36%	**46**% [(4.4/10)+(4.8/10)/2]= 0.46X100=46%	**N/A**

How are beneficiary costs assigned to clinicians?

Calculation of claims-based cost measures requires attribution of beneficiaries and their costs to clinicians. Under MIPS, CMS will attribute cost measures at the TIN-NPI level. Although cost measures will be attributed (or assigned) to individual clinicians, CMS can assess cost measure performance at either the individual clinician, group, or Virtual Group level. For those participating in MIPS as a group or Virtual Group, Cost performance category scores will be determined by aggregating the performance of the individual clinicians within the TIN (groups) or TINs (Virtual Groups). The method used to attribute beneficiary costs to MIPS eligible clinicians at the TIN-NPI level differ between the two measures.

How are beneficiaries attributed to the Total Per Capita Costs (TPCC) measure?

For the TPCC measure, beneficiaries who received a primary care service during the performance period are eligible to be assigned to a single TIN-NPI based on (1) the amount of services, in terms of allowed charges, a beneficiary received and (2) the specialties of the clinicians who provided the services.

A beneficiary is attributed to a single TIN-NPI or to a single entity's CMS Certification Number (CCN) assigned to either a Federally-Qualified Health Center (FQHC) or Rural Health Clinic (RHC) in one of two steps, described below.

Please note: if a beneficiary is attributed to an FQHC or RHC's CCN, then that beneficiary and the beneficiary's costs are not included in the TPCC measure calculated for an individual MIPS eligible clinician or group and the beneficiary is excluded from risk adjustment.

Step 1: If a beneficiary received more primary care services from an individual TIN-NPI that is classified as either a primary care physician (PCP), nurse practitioner (NP), physician assistant (PA) or clinical nurse specialist (CNS) than from any other TIN-NPI during the performance period, then the beneficiary is attributed to that TIN-NPI. If, during the performance period, a beneficiary received more primary care services from an FQHC or RHC's CCN than from any other TIN-NPI, then the beneficiary is attributed to the CCN of the FQHC or RHC.

Step 2: If a beneficiary did not receive a primary care service from a TIN-NPI classified as either a PCP, NP, PA or CNS during the performance period, then the beneficiary may be assigned to a TIN-NPI in "Step 2." If a beneficiary received more primary care services from a specialist physician's TIN-NPI than from any other provider's TIN-NPI during the performance period, then the beneficiary is assigned to the specialist physician's TIN-NPI. For a list of medical specialties included in Step 2, please refer to Table 4 of the 2018 MIPS TPCC Measure Information Form. For a list of Healthcare Common Procedure Coding System (HCPCS) codes that identify primary care services, please refer to Table 2 of the same document.

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How are beneficiary costs attributed to clinicians for the Medicare Spending Per Beneficiary (MSPB) measure?

Each beneficiary MSPB episode is attributed to a single TIN-NPI who billed the most allowed charges during the period between the index admission date and the discharge date.

The following Part B services billed by MIPS eligible clinicians are considered when assigning MSPB episodes to clinicians:

- Part B services billed on the admission date and in a hospital setting with place of service (POS) restricted to inpatient hospital, outpatient hospital, or emergency room;
- Part B services billed by MIPS eligible clinicians during the index hospital stay, regardless of POS; or
- Part B services billed by MIPS eligible clinicians on the discharge date with a POS restricted to inpatient hospital.

If two TIN-NPIs tie for the plurality of services provided to a beneficiary, then the episode is attributed to the TIN-NPI with the most Part B services bill lines during an episode's index hospitalization.

Please refer to the Cost Performance Category fact sheet for additional information about beneficiary attribution in the MSPB measure.

Can the Cost performance category be reweighted?

For a cost measure to be scored, an individual MIPS eligible clinician, group or Virtual Group must have enough attributed cases to meet or exceed the case minimum for that cost measure. If neither measure can be scored, the MIPS eligible clinician/group/Virtual Group will not be scored on Cost and the Quality performance category will be reweighted to 60% of their 2018 MIPS Final Score, the Improvement Activities (IA) performance category will be reweighted to 15% and the Promoting Interoperability (PI) performance category will be reweighted to 25%.

We have extended our extreme and uncontrollable circumstance policy to the Quality, Cost, and Improvement Activities performance categories beginning with the 2018 performance year. Please refer to Appendix B for more information on category reweighting, including the extreme and uncontrollable circumstances policy.

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MIPS IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY

How are my activities assessed and scored?

You can earn up to 40 points in the Improvement Activities performance category.

Improvement activities have been assigned to one of two categories: medium-weighted or high-weighted. High-weighted activities earn twice as many points as medium-weighted activities.

Generally speaking, clinicians, groups and Virtual Groups will receive the following points for their submitted activities:			
medium-weighted activities	= **10** Points	high-weighted activities	= **20** Points

To earn the maximum score of 40 points for the Improvement Activities performance category, you can pick any of these:			
2 high-weighted activities	**1** high-weighted activity	and **2** medium-weighted activities	**4** medium-weighted activities

More points are given for improvement activities for clinicians, groups and Virtual Groups identified with a 1) small practice designation (15 or fewer NPIs), 2) non-patient facing designation, 3) health professional shortage area (HPSA) or 4) rural designation on the **QPP Participation Status lookup tool**.

Other Factors

These may be automatically received or you may apply for them. Learn more about special statuses and hardship exceptions.

Received as an individual

SPECIAL STATUS Small practice	Yes

Received as a group

SPECIAL STATUS Small practice	Yes

Clinicians, groups and virtual groups with these special designations will receive the following points for their submitted activities:

medium-weighted activities	=	**20** Points	high-weighted activities	=	**40** Points

To earn the maximum 40 points for the Improvement Activity performance category, they can complete either:
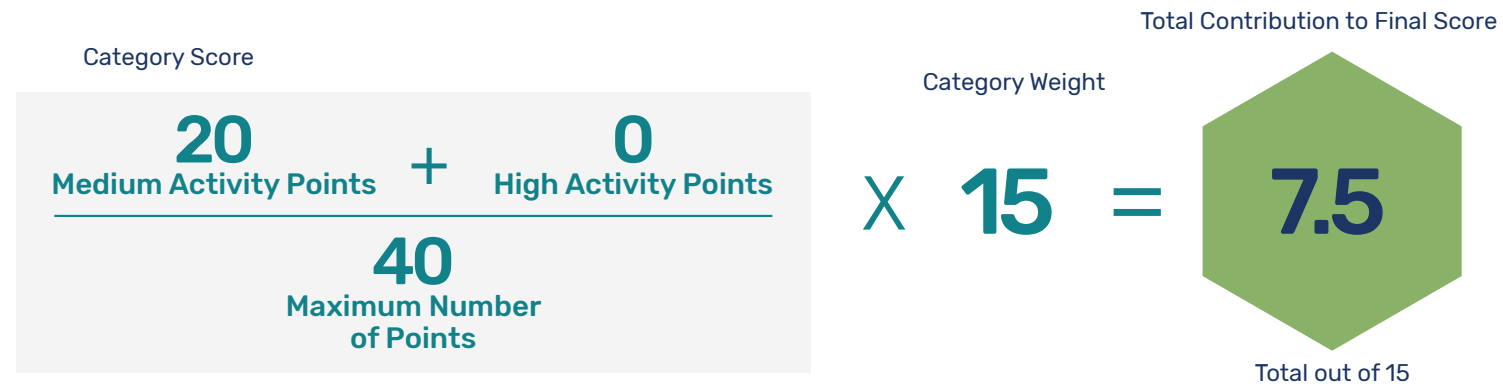
1 high-weighted activity	**2** medium-weighted activities

To learn more, see the MIPS Improvement Activities Fact Sheet or get a list and description of improvement activities.

Scoring Examples

Scenario 1: You are a MIPS eligible clinician who is not in a small, rural or HPSA practice and therefore do not qualify for special scoring for improvement activities. You complete 2 medium-weighted improvement activities and earn 20 of 40 points in this performance category, so 20 of 40 = 50% total possible available points for the Improvement Activities performance category. Your Improvement Activities performance category score is 50%. Your weighted Improvement Activities performance category score is your Improvement Activities performance category score (50%) multiplied by the Improvement Activities performance category weight (15%), which equals 7.5%.

Category Score

$$\frac{\textbf{20} \text{ Medium Activity Points} + \textbf{0} \text{ High Activity Points}}{\textbf{40} \text{ Maximum Number of Points}}$$

Category Weight

X **15** =

Total Contribution to Final Score

7.5

Total out of 15

Scoring Examples, *continued*

Scenario 2: You are a clinician in a small practice and complete 2 medium-weight improvement activities and earn 40 of 40 points in the performance category, so 40 of 40 = 100% of available points for Improvement Activities. Your Improvement Activities score is 100%. Your weighted Improvement Activities score is your improvement activities score (100%) multiplied by the Improvement Activities performance category weight (15%), which equals 15%

Category Score

$$\frac{40 \text{ Medium Activity Points} + 0 \text{ High Activity Points}}{40 \text{ Maximum Number of Points}}$$

Total Contribution to Final Score

Category Weight

X **15** = **15**

Total out of 15

How is my Improvement Activities performance category percent score calculated?

Improvement
Actitivites
Performance
Category Percent
Score
=

$$\frac{\text{Total Points Earned for Completed Activities}}{\text{Total Possible Points (40)}}$$

Your Improvement Activities performance category percent score is then multiplied by the 15% Improvement Activities performance category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS final score.

THE MAXIMUM SCORE IS 100% OF THE CATEGORY WEIGHT.

Can the Improvement Activities performance category be reweighted?

We have extended our extreme and uncontrollable circumstance policy to the Quality, Cost and Improvement Activities performance categories beginning with the 2018 performance year. Please refer to Appendix B for more information on category reweighting, including the extreme and uncontrollable circumstances policy.

How does scoring work if I'm in a patient-centered medical home, or an APM?

- If you're in a certified or recognized patient-centered medical home, comparable specialty practice, or an APM designated as a Medical Home Model, you'll earn full credit for the Improvement Activities performance category by attesting to it during the submission period.

- For 2018 group participation, at least 50% of all site locations under the TIN must meet this criteria in order for the entire TIN to qualify for the full credit.

- For 2018 Virtual Group participation, at least 50% of all site locations across all the TINs in the Virtual Group must meet this criteria in order for the entire Virtual Group to qualify for the full credit.

MIPS PROMOTING INTEROPERABILITY PERFORMANCE CATEGORY

*formerly Advancing Care Information

How does Promoting Interoperability scoring work?

For the 2018 performance period, there are 3 scores that make up the Promoting Interoperability performance category score:

Base Score
50%

Performance Score
UP TO
90%

Bonus Score
UP TO
25%

If your Promoting Interoperability performance category percent score is 100 or more, you will receive the full 25 points for this category in the final score. Just like the Quality and Improvement Activities performance categories, scores that exceed 100% of the total possible category score are capped at 100%.
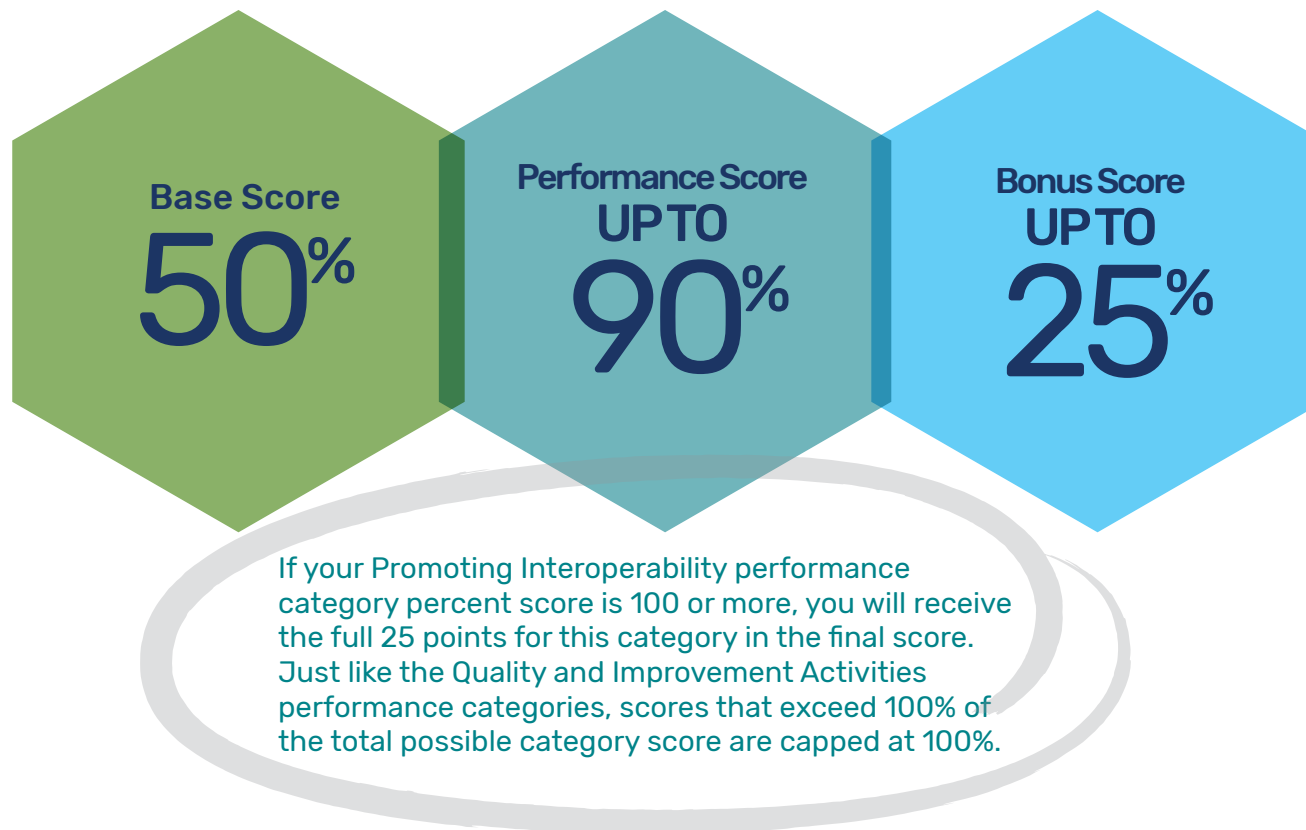
How are base score measures assessed in the Promoting Interoperability performance category for Year 2 (2018)?

Required Base Score-worth

50%

You must meet the requirements of all the base score measures to earn the 50% base score. If you don't meet the base score requirements, you'll get a base score of 0 and a Promoting Interoperability performance score of 0.

To receive the 50% base score, you must submit a "**yes**" for the Security Risk Analysis measure, and **at least a 1** in the numerator for the rest of the measures, unless you qualify for and claim the exclusion for the E-Prescribing measure or Health Information Exchange measure(s). (For more information on these exclusions, please refer to the Promoting Interoperability Performance Category Fact Sheet.)

There are two measure set options for reporting. The option you use is dependent on your certified EHR Edition, either the 2014 Edition or the 2015 Edition. For further information, visit Promoting Interoperability Requirements.

The base score Promoting Interoperability measures are:
1. Security Risk Analysis
2. E-Prescribing
3. Provide Patient Access*
4. Send a Summary of Care*
5. Request/Accept a Summary of Care*

The base score Promoting Interoperability transition measures are:
1. Security Risk Analysis
2. E-Prescribing
3. Provide Patient Access*
4. Health Information Exchange*

*Some base score measures are also performance score measures, so you'll be able to earn a performance score that adds to the base score for submitting these measures.

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How are performance measures scored in the Promoting Interoperability performance category?

Performance Score-worth up to

90%

The performance score is calculated by using the numerators and denominators submitted for measures included in the performance score, or for one measure, by the yes or no answer submitted.[1] For each measure with a numerator/denominator, the percentage score is determined by the performance rate. Most measures are worth a maximum of 10 percentage points, except for two measures reported under the Promoting Interoperability Transition measures, which are worth up to 20 percentage points.[2]

Each measure is worth up to 10% (two measures are worth up to 20%[2]) and the percentage score is based on the performance rate for each measure:

Performance Rate	Percentage Score
Performance rate >0-10	1%
Performance rate 11-20	2%
Performance rate 21-30	3%
Performance rate 31-40	4%
Performance rate 41-50	5%
Performance rate 51-60	6%
Performance rate 61-70	7%
Performance rate 71-80	8%
Performance rate 81-90	9%
Performance rate 91-100	10%

[1] The only performance score measures that have yes/no responses are the Public Health and Clinical Data Registry Reporting measures and the Public Health Reporting measures. MIPS eligible clinicians who are actively working with a public health agency or clinical data registry who submit a "yes" for one of these measures would receive the full 10%.

[2] For the Promoting Interoperability transition measures, the Provider Patient Access measure and Health Information Exchange measure are worth up to 20 percentage points.

[3] As long as you submit a numerator of at least one patient, the measure will earn a minimum percentage score of 1%.

Example: A MIPS clinician submits a numerator and denominator of 85/100 for the patient-specific education measure and has a performance rate of 85%, earning 9 out of 10 percentage points for that measure.

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There are 2 options for submitting performance measures, based on whether you are using the 2014 Edition and/or 2015 Edition of CEHRT:

1) Report up to 9 Promoting Interoperability Measures:	
Measure	**Percentage Score**
Provide patient access	**Up to 10%**
Patient-specific education	**Up to 10%**
View, download and transmit (VDT)	**Up to 10%**
Secure messaging	**Up to 10%**
Patient-generated health data	**Up to 10%**
Send a summary of care	**Up to 10%**
Request/accept summary of care	**Up to 10%**
Clinical information reconciliation	**Up to 10%**
One of the Public Health and Clinical Data Registry Reporting Measures	**0 or 10%**

2) Report up to 7 Promoting Interoperability Transition Measures:	
Measure	**Percentage Score**
Provide patient access	**Up to 20%**
Health information exchange	**Up to 20%**
View, download and transmit (VDT)	**Up to 10%**
Patient-specific education	**Up to 10%**
Secure messaging	**Up to 10%**
Medication reconciliation	**Up to 10%**
One of the Public health and clinical data registry reporting measures	**0 or 10%**

The **Promoting Interoperability Measure Specifications** can give you more details on Promoting Interoperability measures.

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How are bonus points scored in the Promoting Interoperability performance category?

Bonus Score-worth up to 25%

You can earn bonus percentage points by:

- Reporting "yes" to 1 or more additional public health and clinical data registry reporting measures or one of the public health reporting measures beyond the one reported for the performance score (**5% bonus**). **Note:** *This bonus is 5% regardless of the number of additional public health and clinical data registry measures submitted.*

- Reporting "yes" that you completed at least 1 of the specified improvement activities using certified EHR technology (CEHRT) and attest to having completed the qualifying activity in the Improvement Activities performance category (**10% bonus**).

- Reporting exclusively from the Promoting Interoperability Objectives and Measures set using only 2015 Edition CEHRT (**10% bonus**).

If you do all three, you'll earn a 25% total bonus score.

Below are the public health and clinical data registry reporting measures that an eligible clinician may report to for the 5% bonus score:

Promoting Interoperability Measures:
- Syndromic surveillance reporting
- Electronic case reporting
- Public health registry reporting
- Clinical data registry reporting
- Immunization registry reporting

Promoting Interoperability Transition Measures:
- Syndromic surveillance reporting
- Specialized registry reporting
- Immunization registry reporting

You can earn a **10% bonus** *for using CEHRT to perform certain improvement activities. To earn this bonus, you must attest to an eligible activity in the Improvement Activities category AND attest that you completed an eligible activity using CEHRT in the Promoting Interoperability performance category.* Appendix B *of the* Promoting Interoperability Performance Category Fact Sheet *has more details about the improvement activities which qualify for the bonus.*

How does the Promoting Interoperability performance category scoring work?

The Promoting Interoperability performance category continues to be 25% of your final score in Year 2.
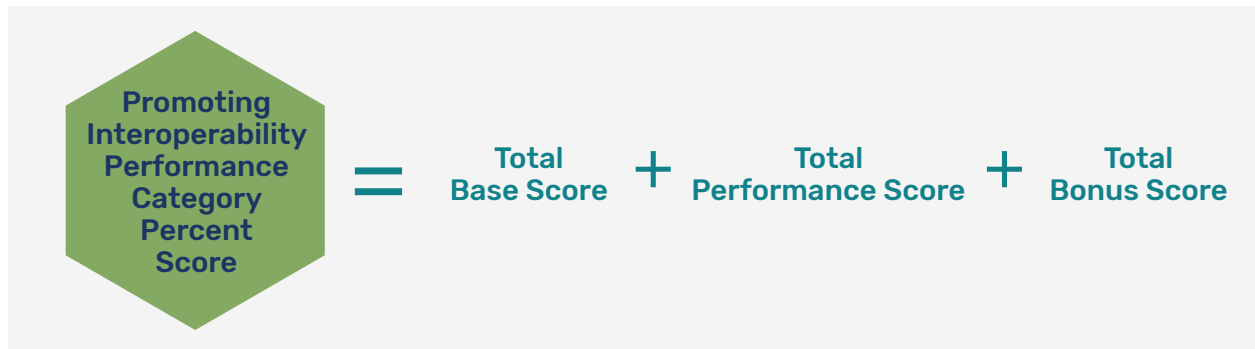
Promoting Interoperability Performance Category Percent Score **=** Total Base Score **+** Total Performance Score **+** Total Bonus Score

Your Promoting Interoperability performance category percent score is then multiplied by the 25% category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS final score.

Example:

Category Score

$$\frac{50\% \text{ Base Score} + 30\% \text{ Performance Score} + 0 \text{ Bonus Points}}{100^* \text{ Maximum Number of Points}} = 80\% \text{ PI Category Score} \times 25\% \text{ Category Weight} = 20$$

Total Contribution to Final Score

The maximum performance category score is **100%***
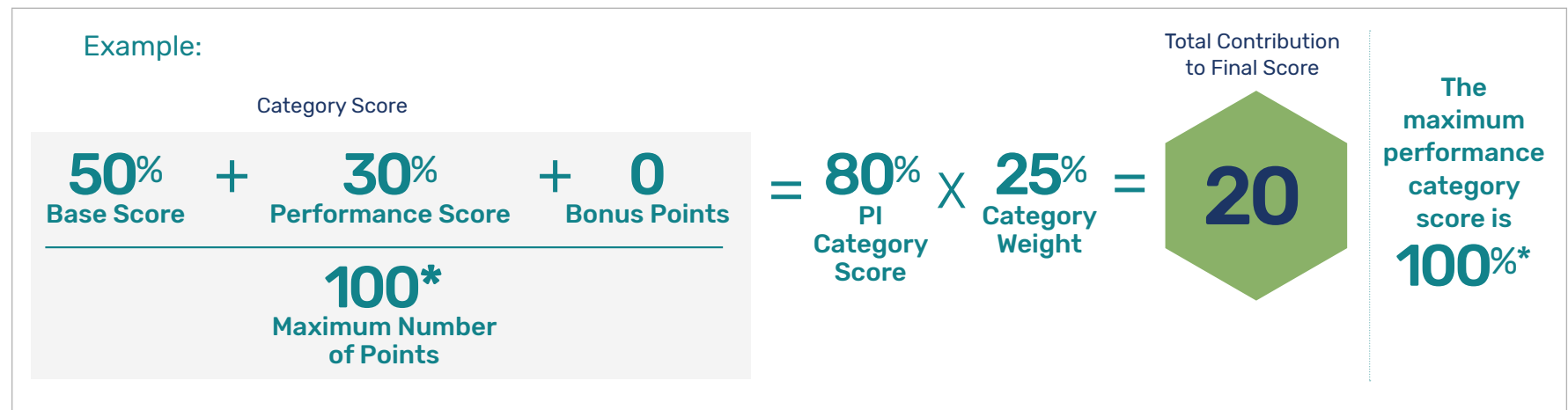
Can the Promoting Interoperability performance category be reweighted?

There are 2 ways the Promoting Interoperability performance category will be reweighted to zero percent:

1) You or your group may submit a Quality Payment Program Hardship Exception Application, citing one of the following specified reasons for review and approval:

- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT
- Small Practice
- Decertified EHR

If we approve your application, then the Promoting Interoperability performance category will be reweighted. Learn more about **hardship exceptions**.

2) You qualify for automatic reweighting. For 2018, you qualify for automatic reweighting if the QPP Participation Status lookup tool identifies you as any of the following:

- Hospital-based clinician
- Ambulatory Surgical Center (ASC)-based clinician
- Non-patient facing clinician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

Other Factors

These may be automatically received or you may apply for them. Learn more about special statuses and hardship exceptions

Received as an individual

SPECIAL STATUS Non-patient facing	Yes
SPECIAL STATUS Small practice	Yes

*NOTE: If you have an approved hardship exception or qualify for automatic reweighting, **we'll reweight the category to 0% and assign the 25% to the Quality performance category** so you can earn up to 100 points in your MIPS final score. However, you can still report if you want to. If you submit data on the measures for the Promoting Interoperability performance category either as an individual, a group, or Virtual Group, then we'll score your performance just like any other clinician in MIPS and weight your Promoting Interoperability performance category at 25% of the final score.*

How does reweighting work if we are participating as a group or virtual group?

A group or Virtual Group's Promoting Interoperability performance category score will be reweighted when:

- The group or virtual group has an approved hardship exception

- The group or virtual group has a hospital-based, ASC-based, or non-patient facing designation at the group or virtual group level

- All of the MIPS eligible clinicians in the group or virtual group individually qualify for reweighting (automatically or through a hardship exception)

If your group or virtual group doesn't meet one of the criteria above, you will not qualify for reweighting and will have to submit data for the Promoting Interoperability performance category.

Just as with individual participation, groups and Virtual Groups who qualify for reweighting but submit data in this category will be scored just like any other clinician in MIPS and your Promoting Interoperability performance category will be weighted at 25% of the final score.

BONUS POINTS ADDED TO FINAL SCORE

Small Practice Bonus

MIPS eligible clinicians, groups and Virtual Groups identified as small practices (those with 15 clinicians or fewer) will automatically receive 5 points added to their final score if they submit data in at least one category (Quality, Promoting Interoperability, or Improvement Activities). These bonus points are not available to MIPS eligible clinicians, groups and virtual groups that are only scored on cost measures.

Complex Patient Bonus

How am I assessed for the Complex Patient Bonus?

When determining bonus points for your care of complex patients, we look at two indicators:

- The medical complexity of your Medicare Part B patients as measured through average Hierarchical Condition Category (HCC) risk scores; and
- Social risk identified for your Medicare Part B patients as measured through the proportion of patients with dual eligible status (qualified to receive both Medicare and Medicaid benefits).

HCC risk scores are calculated annually, based on the following information from the calendar year:

- A beneficiary's age and gender;
- Whether the beneficiary is eligible for Medicaid, first qualified for Medicare on the basis of disability, or lives in an institution (usually a nursing home); and
- The beneficiary's diagnoses.

For the 2018 MIPS performance period, we will use HCC risk scores based on data from the 2017 calendar year (January 1 – December 31, 2017).

All MIPS eligible clinicians, groups, and Virtual Groups who submit data in at least one category can expect to receive a complex patient bonus, ranging from 0 to 5 points, with clinicians in the lowest quartile (based on HCC risk scores) receiving a bonus of about 2.5 points, and clinicians in the highest quartile receiving about 3.7 points (based on historical data).

How is my Complex Patient Bonus calculated?

First, we will identify the Part B beneficiaries you treat between September 1, 2017 – August 31, 2018 and average their 2017 HCC risk scores.

Second, we will determine the proportion of dually eligible beneficiaries you treated between September 1, 2017 – August 31, 2018 and multiply this number by 5.

Third, we will add these numbers together. The sum of these two numbers will be your complex patient bonus, which will be added to your performance category scores. The complex patient bonus cannot exceed 5 points.

Individuals

$$\frac{[\text{sum of all risk scores for the unique beneficiaries you treated between 9/1/17 and 8/31/18}]}{[\text{the number of unique beneficiaries you treated between 9/1/17 and 8/31/18}]} + \left(\frac{[\text{unique patients you treated who were dually eligible for Medicare and full- and partial-benefit Medicaid}]}{[\text{unique Medicare beneficiaries you treated}]} \times 5 \right) = \text{Your Complex Patient Bonus}$$

continued

Groups

$$\frac{[\text{sum of all risk scores for the unique beneficiaries treated by all NPIs in the TIN}]}{[\text{the number of unique beneficiaries treated by all NPIs in the TIN}]} + \left(\frac{[\text{unique patients treated by the NPIs in the TIN who were dually eligible for Medicare and full- and partial-benefit Medicaid}]}{[\text{unique Medicare beneficiaries treated by the NPIs in the TIN}]} \times 5 \right) = \text{Your Complex Patient Bonus}$$

Virtual Groups

$$\frac{[\text{sum of each individual NPI's average HCC risk score}] \times [\text{the number of unique beneficiaries treated by the NPI in the Virtual Group}]}{[\text{sum of the beneficiaries cared for by each NPI in the Virtual Group}]} + \left(\frac{[\text{unique patients treated by the NPIs in the Virtual Group who were dually eligible for Medicare and full- and partial-benefit Medicaid}]}{[\text{unique Medicare beneficiaries treated by the NPIs in the Virtual Group}]} \times 5 \right) = \text{Your Complex Patient Bonus}$$

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MIPS FINAL SCORE AND PAYMENT ADJUSTMENT

Calculating the payment adjustment based on the MIPS final score

How is my Final Score calculated?

Final Score

Quality + **Cost** + **Improvement Activities** + **Promoting Interoperability** + **Bonus Points** → X **100** = **Final Score**

Quality performance category percent score x Quality performance category weight

Cost performance catergory percent score X Cost performance category weight

Improvement Activities performance category score X improvement Activities performance category weight

Promoting Inteoperability performance category score X actual Promoting Interoperability performance category weight

Calculating the Final Score under MIPS

Scenario:

A MIPS eligible clinician works at large, urban practice and participated in MIPS as an individual.

- Quality: 68.1% x 50% x 100 = 34.05 points toward the final score
- Cost: 46% x 10% x 100 = 4.6 points toward the final score
- Improvement Activities: 75% x 15% x 100 = 11.25 points toward the final score

- Promoting Interoperability: 80% x 25% x 100 = 20 points toward the final score
- Small practice bonus = 0 points toward the final score
- Complex patient bonus = 3.2 points toward the final score
Final score = 75.6 points

Calculating the payment adjustment based on the MIPS final score

The MIPS final score will be between 0 and 100 points. How is the payment adjustment based on the MIPS final score calculated?

Final score	Payment adjustment
70.00 – 100.00 points (Exceptional performance threshold = 70.00 points)	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Eligible for additional adjustment for exceptional performance (subject to a scaling factor to account for available funds)
15.01–69.99 points	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Not eligible for additional adjustment for exceptional performance
15.00 points (Performance threshold = 15.00 points)	• Neutral MIPS payment adjustment (0%)
3.76-14.99	• Negative MIPS payment adjustment greater than -5% and less than 0%
0-3.75 points	• Negative MIPS payment adjustment of -5%

There are
two MIPS payment
adjustments

## The First Applies to

All MIPS
Eligible
Clinicians

MIPS Payment Adjustment – The first payment adjustment is calculated in a way to ensure budget neutrality. Clinicians at the performance threshold of 15 points earn a neutral adjustment. Clinicians above the performance threshold of 15 points earn a positive payment adjustment, which is subject to a scaling factor. Clinicians below the performance threshold of 15 points will be subject to a negative adjustment. The maximum negative adjustment is -5%.

The final MIPS payment adjustments will be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold.

More MIPS eligible clinicians with final scores above the performance threshold means the scaling factors would decrease because more eligible clinicians receive a positive MIPS payment adjustment. In this case, the maximum positive payment adjustment factor could be considerably less than 5%.

More MIPS eligible clinicians with final scores below the performance threshold means the scaling factors would increase because more eligible clinicians would have negative MIPS payment adjustments and relatively fewer eligible clinicians would receive positive MIPS payment adjustments. In this case, the maximum positive payment could exceed 5%.

The Second is an Additional Payment Adjustment for Exceptional Performance that Applies Only to:

Final Score at

+ 70

Points or Higher

**All MIPS
Eligible Clinicians**
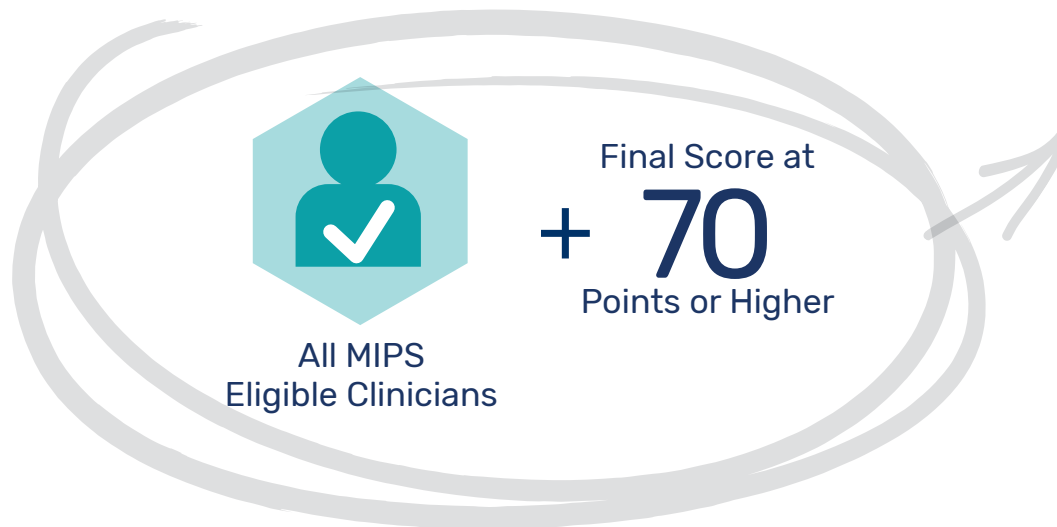
Additional Adjustment for Exceptional Performance – This adjustment is available to MIPS eligible clinicians (participating as an individual, a group, or virtual group) with a final score of 70 points or higher. The amount of the adjustment is also applied on a linear scale so that clinicians with higher scores receive a higher adjustment. The amount of the adjustment is scaled based on availability of funds; it will depend on the scores and the number of clinicians receiving a final score of 70 or higher.

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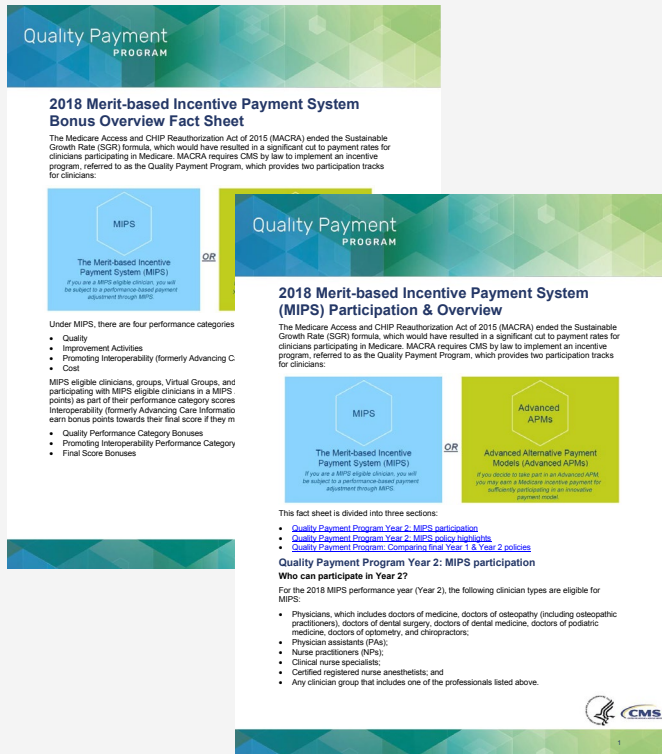
Access additional resources by clicking on the links below:

- 2018 Quality Benchmarks
- CAHPS for MIPS Fact Sheet
- CMS Web Interface Fact Sheet
- MIPS Cost Performance Category Fact Sheet
- MIPS Improvement Activities Performance Category Fact Sheet
- MIPS Promoting Interoperability Performance Category Fact Sheet
- MIPS Participation Fact Sheet
- Bonus Overview Fact Sheet
- MIPS Group Participation User Guide
- Physician and Other Supplier Data CY 2015
- Risk Adjustment (for information on mapping ICD-10 codes)

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Glossary

ACO

Accountable Care
Organization

APM

Advanced Payment
Model

CAHPS

Consumer Assessment
of Healthcare Providers
and Systems

CEHRT

Certified Electronic
Health Record
Technology

CMS

Centers for Medicare &
Medicaid Services

EHR

Electronic Health
Record

MIPS

Merit-based Incentive
Payment System

MSPB

Medicare Spending Per
Beneficiary

NPI

National Provider
Identifier

OCM

Oncology Care Model

PQRS

Physician Quality
Reporting System

QCDR

Qualified Clinical Data
Registry

QP

Qualifying APM
Participant

TIN
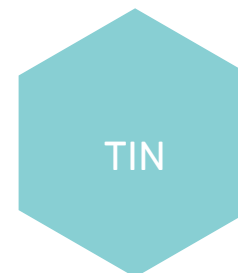
Taxpayer Identification
Number

VM

Value-Based Payment
Modifier

APPENDIX

Appendix A: Scoring Quality Measures

This example can help you find a benchmark, figure achievement points, and pick the top 6 measures based on the number of points.

....

1. Find the benchmark and figure achievement points given by different submission mechanisms for the same measure.
Achievement points are figured by mapping the performance rate to the benchmark by submission method.

Measures reported	Type of measure	Submission method	Measure performance rate	Cases reported
Measure 130 – Document Current Meds	Process	EHR	97.64 (mapped to highlighted decile below)	90

Measure name	Measure ID #	Submission method	Measure type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Documentation of current medications in the medical record	130	Claims	Process	Y	97.20 – 99.23	99.24 – 99.79	99.80 – 99.99	—	—	—	—	100.00
Documentation of current medications in the medical record	130	EHR	Process	Y	86.25 – 91.91	91.92 – 94.85	94.86 – 96.69	96.70 – 97.98	97.99 – 98.87	98.88 – 99.54	99.55 – 99.95	>= 99.96
Documentation of current medications in the medical record	130	Registry/ QCDR	Process	Y	77.08 – 90.22	90.23 – 95.97	95.98 – 98.60	98.61 – 99.69	99.70 – 99.99	—	—	100.00

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Appendix A: Scoring Quality Measures

2. Figuring achievement points in a decile

a. Determine the decile that the performance rate falls in:

MEASURE PERFORMANCE RATE = 97.64

Measure name	Measure ID #	Submission method	Measure type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Documentation of current medications in the medical record	130	EHR	Process	Y	86.25 – 91.91	91.92 – 94.85	94.86 – 96.69	96.70 – 97.98	97.99 – 98.87	98.88 – 99.54	99.55 – 99.95	>= 99.96

b. Apply the following formula based on the measure performance and decile range:

$$\text{Achievement Points} = X + \frac{(q - a)}{(b - a)}$$

$$\text{Achievement Points} = 6 + \frac{(97.64 - 96.70)}{(97.99^* - 96.70)}$$

Achievement Points

=6.7

X = decile #

q = performance rate

a = bottom of decile range

b = top of decile range

Note: *Partial achievement points are rounded to the tenths digit for partial points between 0.01 to 0.89. Partial achievement points above 0.9 are truncated to 0.9.*

continued

Appendix A: Scoring Quality Measures

3. Repeat assignment of achievement points for each submitted measure

Clinician reports by EHR, 100% data completeness for all measures.

Measures reported	Type of measure	Measure performance rate	Cases reported	Achievement points	Comments
Measure 130 – document current meds	Process	97.64	90	6.7	Compare to benchmark
Measure 111 – pneumococcal vaccination for elderly	Process	22.12	112	3.7	Compare to benchmark
Measure 113 – colorectal cancer screening	Process	36.32	13	3.0	Below 20 case minimum; assign 3 points
Measure 119 – diabetes: attention for nephropathy	Process	77.19	43	5.4	Compare to benchmark
Measure 226 – preventive care – tobacco	Process	49.33	32	3.0	Compare to benchmark; apply 3 point floor due to poor performance
Measure 236 – controlling high blood pressure	Outcome	63.82	86	5.9	Compare to benchmark
Measure 238 – use of high-risk meds in elderly	Process*	2.01	40	5.7	Compare to benchmark

These measures are inverted for scoring purposes.

Assumptions: *measures meet data completeness/case minimum unless stated otherwise; measures are submitted by EHR; measures are scored on achievement for the submitted outcome measure and next 5 highest scored measures. Although not shown in this example, the next 5 highest scored measures could include another outcome measure; the all-cause readmission doesn't apply; CEHRT bonus points are available for all measures meeting bonus criteria.*

continued

Appendix A: Scoring Quality Measures

4. Pick the top 6 measures based on achievement points

Measures sorted by measure number	Types of measure	Measure performance rate	Achievement points
Measure 130 – document current meds	Process	97.64	6.7
Measure 111 – pneumococcal vaccination for elderly	Process	22.12	3.7
Measure 113 – colorectal cancer screening	Process	36.32	3.0
Measure 119 – diabetes: attention for nephropathy	Process	77.19	5.4
Measure 226 – preventive care – tobacco	Process	49.33	3.0
Measure 236 – controlling high blood pressure	Outcome	63.82	5.9
Measure 238 – use of high-risk meds in elderly	Process	2.01	5.7

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Then, sort the measures based on achievement points. Put the outcome measure first, then sort the rest of the measures from highest to lowest points.

Measures sorted by Achievement points	Performance rate	Achievement points
1. Outcome/ high-priority: Measure 236	63.82	5.9
2. Measure 130	97.64	6.7
3. Measure 238	2.01	5.7
4. Measure 119	77.19	5.4
5. Measure 111	22.12	3.7
6. Measure 113	36.32	3.0
The following measure isn't included in the quality score:		
Measure 226	49.33	3.0

Note: *Either measure 113 or 226 could have been included since they both had the same achievement points, but Measure 113 was selected based on ascending numerical order and 113 comes before 226.*

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Appendix B: Reweighting the Performance Categories

Extreme and Uncontrollable Circumstances

An extreme and uncontrollable circumstance is defined as a rare event (i.e. natural disaster or other extraordinary circumstance) that is entirely outside the control of the clinician and/or of the facility and that affects the MIPS eligible clinician's ability to collect and submit information used to generate a performance score for an extended period. Under the Extreme and Uncontrollable Circumstances Policy, we aimed to reduce the burden on MIPS eligible clinicians' located in impacted areas. For Year 2 (2018) of MIPS, the extreme and uncontrollable circumstances reweighting policy extends to all performance categories.

If you experienced an extreme and uncontrollable circumstance during the 2018 performance year, you may qualify for performance category reweighting. If you'd like to be considered for reweighting, please complete the Extreme and Uncontrollable Circumstance Exception Application.

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Performance Category Weight Redistribution

The table below outlines the performance category weights when zero, one or more performance categories is reweighted to 0% based on any circumstances described throughout this guide, including the Extreme and Uncontrollable Circumstances policy.

Performance Category Redistribution for the 2020 MIPS Payment Year				
Reweighting Scenario	**Quality**	**Cost**	**Improvement Activities - IA**	**Promoting Interoperability PI** *(formerly ACI)*
No Reweighting Needed:				
General weighting for all four performance categories	50%	10%	15%	25%
Reweighting One Performance Category				
No Cost *Cost > Quality*	60%	0%	15%	25%
No Promoting Interoperability *PI > Quality*	75%	10%	15%	0%
No Quality *Quality > IA and PI*	0%	10%	45%	45%
No Improvement Activities *IA > Quality*	65%	10%	0%	25%

continued

Reweighting Scenario	Quality	Cost	Improvement Activities - IA	Promoting Interoperability PI (formerly ACI)
Reweighting Two Performance Categories				
No Cost and no Promoting Interoperability *Cost and PI > Quality*	85%	0%	15%	0%
No Cost and no Quality *Cost and Quality > IA and PI*	0%	0%	50%	50%
No Cost and no Improvement Activities *Cost and IA > Quality*	75%	0%	0%	25%
No Promoting Interoperability and no *Quality PI and Quality > IA*	0%	10%	90%	0%
No Promoting Interoperability and no *Improvement Activities PI and IA > Quality*	90%	10%	0%	0%
No Quality and no Improvement Activities *Quality and IA > PI*	0%	10%	0%	90%

Version History

Date	Change Description
6/14/19	p. 15 and 73 – Made updates to note that when the points are the same, the system uses the measure ID to determine which one will be included in the top 6.
	p. 33 – Corrected the number of achievement points assigned to each scored measure to 1–10. Guide previously stated that 3–10 achievement points were assigned to each scored measure.
10/28/18	Original Posting

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