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Physician CONNECTION

Deep Dive: The MIPS Four Performance Measures

By Christopher Bell

When it comes to the Quality Payment Program (QPP) and moving Medicare Part B clinicians to a performance-based payment system, most practices know by now that there are two tracks to choose from—Advanced Alternative Payment Models (APMs) or the Merit-Based Incentive Payment System (MIPS). For 2017, MIPS has four performance categories, weighted as follows:

1. Quality (replaces Physician Quality Reporting System)—60 percent of score
2. Cost (replaces value-based modifier)—0 percent of score
3. Improvement activities (new category)—15 percent of score
4. Advancing care information (replaces Meaningful Use)—25 percent of score

Qualification

Let's review the basics of who can participate in the QPP. To qualify for the QPP, you must bill more than $30,000 to Medicare Part B and provide care for more than 100 Medicare patients per year. If you decide to participate in MIPS, you may earn a performance-based payment adjustment.

For MIPS you must also be a:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

You cannot participate in MIPS if:

- You are newly enrolled in Medicare (2017 is your first year participating)
- You are below the low-volume threshold, which means you bill less than $30,000 and provide care for fewer than 100 Medicare patients per year
- You participate in an advanced APM

You can choose to report as an individual or group. Choosing to report as a group means your practice has more than two clinicians whose individual National Provider Identifiers (NPI) have reassigned their billing rights to a single Tax Identification Number. Your data was aggregated and was submitted as a group.

The first performance period began January 1, 2017, and will close December 31, 2017. To potentially earn a positive payment adjustment under MIPS, you must

send in data about the care you provided and how your practice used technology in 2017 to Content Management System (CMS) by March 31, 2018, for a payment adjustment in 2019. If you have not started, now is the time to pick your pace.

PART 1: Quality

Reporting Quality

The quality portion of MIPS—which accounts for 60 percent of the overall MIPS score—replaces the Physician Quality Reporting

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System (PQRS) and the quality portion of the value-based modifier.

As the largest performance category of MIPS, it is the one with which you'll want to be the most familiar. In this QPP transition year, you can pick your pace. This means you can submit a minimum amount of data for one measure set for 2017 to test your system and determine if you need to make adjustments before reporting in 2018. Or you can do partial reporting, which means submitting at least six quality measures, including at least one outcome measure, between 90 days and one full year. Your third option is to report six measures, including the outcome measure, for the full performance year.

The quality portion of MIPS was created to add some flexibility, focusing on the measures that are important to your practice. Each eligible clinician will select six of 300 available quality measures, which is a decrease from the previous program under PQRS, which had nine measures covering three domains. (CMS no longer requires the domain requirements for this new program.) Of those six measures to report, one must be an outcome measure. If an outcome measure is not available,

the clinician should select another high-priority measure, such as an appropriate use measure, patient experience measure, patient safety measure, efficiency measure or a care coordination measure. You may also select specialty-specific measure sets.

Points for Quality

Within the quality performance category, individual clinicians will need to select six measures to report. Clinicians receive a minimum of three points for reporting the range of measures, depending on the performance against the benchmark for the measure. (Visit the QPP website under education and tools to review the quality benchmarks for each measure.) In year one of the QPP, participants automatically receive at least three points for simply completing and submitting a measure. Therefore, if you submit any measure, either under the test category or for the full year, the minimum points you would receive would be three. If a measure cannot be reliably scored against the benchmarks, the clinician will still receive the minimum three points.

The quality category of MIPS determines your performance by comparing it to a national benchmark—noting how you stack up against everyone else in the country who reported on the same measure. The benchmarks for the quality component are separated by measure and are specific to the type of data-submission method (e.g., EHRs, QCDR/Registries, CAHPS and claims). It doesn't matter if you report as an individual clinician or as part of a group, the benchmark will remain the same. To create benchmarks for each measure, CMS takes information that was reported via PQRS two years prior to the current performance year. For CAHPS, benchmarks are set based on two surveys: 2015 CAHPS for PWRS and CAHPS for ACOs. Submissions via the CMS web interface will use benchmarks from the 2017 Medicare Shared Savings Program. For measures with no historic benchmark, CMS will attempt to calculate benchmarks based on 2017 performance data.

To summarize:

- Select six of the 300 available quality measures (to report on for a minimum of 90 days)
  - ❍ Or a specialty set
  - ❍ Or CMS web interface measures
  - ❍ Readmission measure is included for group reporting with groups of at least 16 clinicians and sufficient cases
- Clinicians will receive anywhere from three to 10 points on each quality measure based on performance against benchmarks. Each measure reported requires the following information:
  - ❍ Measure name and ID
  - ❍ Submission type (EHR, QCDR/Registry, claims)
  - ❍ Measure type (e.g., outcome, process)
  - ❍ Whether or not a benchmark could be calculated for that measure/submission mechanism
  - ❍ Whether the benchmark is topped out (i.e., not showing much variability and may have different scoring in the future)
- Failure to submit performance data for a measure = 0 points

Bonus points are available for individual clinicians and those reporting for a group. Bonus points are awarded for:

- Submitting an additional high-priority measure
  - ❍ Two bonus points for each additional outcome and patient experience measure
  - ❍ One bonus point for each additional high-priority measure
- Using CEHRT to submit measures to registries or CMS
  - ❍ One bonus point for submitting electronically end to end

b. If you have a combination of technologies from 2014 and 2015 editions that support these measures

2. 2017 Advancing Care Information Transition Objectives and Measures (which are based on modified Stage 2)
   a. If you have technology certified to the 2015 edition; or
   b. If you have technology certified to the 2014 edition; or
   c. If you have a combination of technologies from 2014 and 2015 editions

In 2017, CMS will accept either technology certified to the 2015 edition or the 2014 edition, but by 2018, all MIPS-eligible clinicians must report using 2015 edition CEHRT.

Calculations

To earn points for advancing care information, you must start with the base score. If you fulfill the base score, you can fulfill the performance score. The performance score is optional, but it can be a good way to increase your score, depending on the measures you choose. Additionally, there is a potential bonus score to earn. The total advancing care information score is calculated from base score plus performance score plus bonus score. This all totals to 25 percent of your MIPS score.

For the base score, depending on the CEHRT, report either the Advancing Care Information Objectives and Measures or the 2017 Advancing Care Information Transition Objectives and Measures. The base score is worth 50 percent of the final advancing care information score.

- To satisfy base score requirements, the MIPS-eligible clinician needs one patient in the numerator (i.e., you only need one patient for each ACI base score measure)
- For measures that overlap between the base and performance score measures, additional patients improve the score

- Clinicians must also submit a numerator/denominator or "Yes/No" response for each of the following required measures:
  - ❍ Advancing Care Information Measures:
    - ❍ Security Risk Analysis
    - ❍ e-Prescribing
    - ❍ Provide Patient Access
    - ❍ Send a Summary of Care
    - ❍ Request/Accept a Summary of Care
  - ❍ 2017 Advancing Care Information Transition Measures
    - ❍ Security Risk Analysis
    - ❍ e-Prescribing
    - ❍ Provide Patient Access
    - ❍ Health Information Exchange

If you've fulfilled the base score, you can try to earn a performance score for 25 percent of your final advancing care information score:

- To earn up to 90 percent of the performance score:
  - ❍ Report up to nine Advancing Care Information measures or
  - ❍ Report up to seven 2017 Advancing Care Information Transition measures
- Each measure is worth 10 to 20 percent. The percentage score is based on the performance rate for each measure.

There are two ways to earn a bonus score for 15 percent of your advancing care information final score:

- Earn a 5 percent bonus for reporting on one or more of the following Public Health and Clinical Data Registry Reporting measures:
  - ❍ Syndromic Surveillance Reporting (14 and 15)
  - ❍ Specialized Registry Reporting (14)
  - ❍ Electronic Case Reporting (15)
  - ❍ Public Health Registry Reporting (15)
  - ❍ Clinical Data Registry Reporting (15)
- Earn a 10 percent bonus for using CEHRT to report certain Improvement Activities

Then the score for advancing care information (25 percent of final score) is totaled (Base + Performance + Bonus):

- Base Score: accounts for 50 percent of the total Advancing Care Information Performance category score
- Performance Score: accounts for up to 90 percent of the Total Advancing Care Information Performance category score
- Bonus Score: accounts for up to 15 percent of the total Advancing Care Information Performance category score

This can add up to a 155 percent maximum score that is capped at 100 and scaled to the 25 performance points available for advancing care information performance. This structure was deliberately created to make sure

the associated surgeon's fee, materials and anesthesia, as well as indirect costs, such as if the patient is continually readmitted to the hospital)
3. Attributing the episode group to one or more responsible clinicians
4. Risk adjusting episode group resources or defining episodes to compare like beneficiaries
5. To the extent possible, aligning episode group costs with indicators of quality

The goal for developing cost measures is to provide clinicians with useful, actionable information that can help to drive lower costs and improve patient outcomes.

PART 3: Improvement Activities

Defining Improvement Activities

The improvement activities performance category of MIPS is new for 2017 (it doesn't replace an old reporting system), and comprises 15 percent of the MIPS score. This category assesses how much you participate in activities that improve clinical practice. Examples include ongoing care coordination, clinician and patient shared decision-making, and expanding practice access. This performance category also includes incentives that help drive participation in certified patient-centered medical homes (PCMH) and alternative payment models (APM).

Most participants will have the flexibility to attest that they have completed four out of 93 improvement activities under nine subcategories for a minimum of 90 days. These nine subcategories are:

1. Expanded practice access
2. Population management
3. Care coordination
4. Beneficiary engagement
5. Patient safety and practice assessment
6. Participation in an APM
7. Achieving health equity
8. Integrating behavioral and mental health
9. Emergency preparedness and response

You can choose to attest to the set of activities that are most meaningful to your practice because there is no reporting requirements subcategory.

Scoring Methodology

Improvement activities can either be medium weighted (for 10 points of the total category score) or high weighted (for 20 points of the total category score). The maximum number of points clinicians can earn in the improvement activities category is 40.

To get the maximum score of 40 points for the improvement activity score, you may select any of these combinations:

- Two high-weighted activities
- One high-weighted and two medium-weighted activities
- Up to four medium-weighted activities

Clinicians who practice in a PCMH or similar specialty practice automatically receive full credit for the category.

There are special considerations for practices with 15 or fewer clinicians, those in rural or geographic health professional shortage areas (HPSA) and nonpatient-facing APM. The number of points assigned to each weighting are different for specific clinicians. Medium-weight activities are worth 20 points each, and high-weight activities are worth 40 points each. To obtain the total score for this category, you can perform one high-weighted activity or two medium-weighted activities.

If you are not participating in an APM, a PCMH or comparable specialty practice and do not select any activity, you will receive zero points in this performance category.

To calculate the score for the improvement activities category, add the total number of points earned for completed activities and divide by the total maximum number of points (40). Then multiply that number by 100 to determine the total score.

PART 4: Advancing Care Information

Understanding Advancing Care Measures

The advancing care information portion of MIPS—which is 25 percent of your MIPS score—promotes patient engagement and the electronic exchange of information using certified EHR technology (CEHRT). This effectively replaces the Medicare EHR Incentive Program for eligible professionals, also known as Meaningful Use.

In 2017 there are two options for reporting. The option you use to submit your data is based on your CEHRT:

1. Advancing Care Information Objectives and Measures (which are based on Stage 3)
   a. Use if you have technology certified to the 2015 edition; or

Quality Calculation

The maximum number of points an individual clinician can earn for the quality component of MIPS is 60. To calculate the total quality performance category score, add the points earned on the required six quality measures you report, plus any bonus points that you receive and divide it by 60.

It's important to note that if you are a clinician for a group of 15 or more, the calculations are different. The maximum number of quality points available to groups of clinicians is 70. This is because those groups are also measured on the readmission measure, which is a CMS-calculated measure based on claims data. Groups of clinicians will only be measured with the readmission measure if they have more than 200 cases. For groups the maximum quality points is 70, which include six measures plus one readmission measure.

Therefore, the CMS web interface reporter total score would be:

- 120 points for groups with complete reporting and the readmission measure
- 110 points for groups with complete reporting and no readmission measure

The total score for other submission measures would be:

- 70 points for six measures plus one readmission measure
- 60 points if a readmission measure does not apply

PART 2: Cost

Understanding Cost Measures

The cost category of MIPS comprises zero percent of your score during this first year of the QPP. During this transition year, CMS is looking at costs and will give you feedback on how you performed, but the category won't be tied to your 2017 reimbursement. It is the only MIPS category that requires nothing from you at this time—CMS will get all the information it needs from the claim data that it already receives.

However, you should not ignore this category. CMS is still determining whether it will use cost as a reporting measure for year 2018, but regardless, it's time to familiarize yourself with the measures. CMS will be giving you feedback.

The cost measures CMS uses for the first year are not new. They are derived from the value-based modifier program and Quality of Resource Use reports. CMS drew from those reports and the MIPS measures that it has spent years developing to get a sense of how they work. Their intent is to start giving clinicians feedback and then transition them into the new MIPS program.

A cost measure represents the Medicare payments (for example, payments under the Physician Fee schedule, Inpatient Prospective Payment System, etc.) for the items and services furnished to a

beneficiary during an episode of care. The episode of care is the basis for identifying items and services through claims that are furnished to address a condition within a specified timeframe. The goal is that cost measures should be aligned with quality of care assessment so that patient outcomes and smarter spending can be pursued together.

Assessing Cost Measures

In this first year, CMS will give feedback on 12 cost measures. Two of the 12 are general cost measures that capture the breadth of what clinicians do:

1. Medicare Spending Per Beneficiary (MSPB)
2. Total cost of care measure

The other 10 measures are episode-based cost measures:

1. Mastectomy
2. Aortic valve surgery
3. Coronary artery bypass graft (CABG)
4. Hip femur fracture or dislocation treatment
5. Cholecystectomy and common bile duct exploration
6. Colonoscopy and biopsy
7. Transurethral resection of the prostate for benign prostatic hyperplasia (BPH)
8. Lens and cataracts procedures
9. Hip replacement or repair
10. Knee arthroplasty or replacement

CMS is currently trying to further determine how to have the episode-based cost measures reflect the type of care clinicians are providing and what they find most meaningful.

Providing Actionable Information

Cost measures require five essential components:

1. Defining an episode group (aortic valve replacements, mastectomies). There are three types:
   a. Chronic condition episode groups
   b. Acute inpatient medical condition episode groups
   c. Procedural episode groups
2. Assigning costs to the episode group (direct costs, such as for carpal tunnel surgery and

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clinicians have the flexibility to work on the measures most important to their practice.

Are You Ready?

With 2017 coming to a close, if you haven't picked your pace for this reporting year, it's your last chance to do so. Here are your options:

- Don't participate in the Quality Payment Program for 2017—If you don't send in any 2017 data, then you receive a negative 4 percent payment adjustment.
- Test—If you submit a minimum amount of 2017 data to Medicare (e.g., one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.
- Partial—If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment and may even earn the max adjustment. Your last chance to collect 90 days of information this year begins on October 1, 2017.

- Full—If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

Pick the pace that is best for your practice.

Also make sure that your EHR meets the 2017 technology requirements. It should be fully certified based on 2014 Edition Certification and the associated CMS regulatory requirements. MACRA requires EHRs to advance to the 2015 Edition Certification by January 2018, so make sure your EHR can support your practice in 2017 and beyond.

For more information on MACRA , visit the CMS website or the Quanum EHR (formerly Care360) MACRA Resources page.

Sources: CMS, Quanum EHR

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