10 FAQs About the Merit-based Incentive Payment System (MIPS)

Updated for 2019

In this FAQ we attempt to explain in one narrative the key aspects of MIPS, as updated for the 2019 performance year, both for those new to the program as well as those with previous experience and familiarity with the 2018 MIPS rules. The FAQs are optimally read in sequential order but also sufficiently standalone to enable skipping to the topic of greatest interest. Our team has referenced, reproduced and curated key excerpts from original CMS source documents, such as Federal Register regulatory rules and CMS fact sheets to enable readers to quickly and easily explore a topic in greater depth based on the source-of-truth CMS document.

On November 1, 2018, CMS released revisions to payment policies under the Medicare Part B physician fee schedule for the Quality Payment Program (QPP) for calendar year 2019 – access Federal Register here. (easier-to-read format here) In accordance with one of the most bipartisan and significant legislative changes to Medicare in a generation, the Medicare Access and CHIP Re-authorization Act of 2015 (MACRA) repeals the legacy Medicare Part B Sustainable Growth Rate (SGR) reimbursement formula and replaces it with the QPP, a new value-based reimbursement system impacting Part B payments to clinicians nationally. The QPP rule is updated at least once per year and consists of two major tracks:

- The Merit-based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)

For the 2019 performance year, CMS predicts that 800,000 Part B clinicians will be subject to MIPS. MIPS is effectively the "new default" for Part B where clinicians are excluded from MIPS only under certain conditions.

Read on for some of the most frequently asked questions about 2019 MIPS, or consult our archived 2018 MIPS FAQs.

Table of Contents

1. What is MIPS?

MIPS is currently CMS' largest value-based care (VBC) payment program and is designed to be a major catalyst towards transforming the healthcare industry from fee-for-service to pay-for-value. MIPS serves as the primary stepping stone for provider organizations to graduate to APMs operated by CMS and tenets of the program have been adopted by other value-based programs. For example, all Advanced APMs must adopt quality measures comparable to those approved for MIPS. There is a public reporting component to MIPS that impacts clinicians' reputations. In early 2019, more than half-a-million clinicians' 2017 MIPS scores will be published by CMS, further expanding the program's influence on the industry's shift towards value-based care.

Every year eligible Medicare Part B clinicians are scored on a 100-point MIPS performance scale which combines and expands upon the legacy Medicare Meaningful Use (MU), Physician Quality Reporting System (PQRS), and Value-Based Modifier (VBM) programs. The clinician's Part B service payments are adjusted up or down based upon the MIPS performance score. These adjustments are applied to the Medicare payment for every Part B service billed by the clinician two years after the performance year, e.g. 2019 is the payment adjustment year for the 2017 performance year. A significant portion of the incentive pool is derived from the penalties applied to poor performers, effectively making MIPS a program where the winners earn rewards at the expense of the losers.

Year-over-year, MIPS raises the level of competition among provider organizations, and increases the financial and reputational impacts to clinicians. CMS and Congress (through the Bipartisan Budget Act) have exercised their authority under MACRA to make the MIPS transition more gradual, allowing CMS to set certain program variables such as the Cost performance category weight to vary between 10% and 30%. The Bipartisan Budget Act mandates that CMS must gradually increase the MIPS performance threshold each year towards becoming the national historical mean or median in the 2022 performance year. For this reason, MIPS can be likened to a "treadmill" which increases in speed and trajectory over time, motivating organizations and clinicians to put quality incentive programs in place now in order to stay ahead of the competition as the program gets more difficult.

Note that MIPS does not impact the Medicaid nor eligible hospital Promoting Interoperability programs. As a result, some clinicians may be subject to both MIPS and the Medicaid Promoting Interoperability program. This is but one example of a clinician being subject to multiple value-based care programs, either from a single payer or across multiple payers.

2. What are the financial and reputational impacts of MIPS?

Overview of Financial Impacts

MACRA defines two types of financial impacts for Medicare Part B clinicians participating in MIPS:

A small, annual inflationary adjustment to the Part B fee schedule
MIPS value-based payment adjustments (incentives or penalties) based on the MIPS 100-point final score

The Medicare Part B inflationary adjustment is an annual +0.5% increase for the payment years 2016 to 2019, which is the first payment year for MIPS associated with the first performance year (2017). There is no inflationary adjustment from 2020 to 2025. A subsequent annual inflationary adjustment of +0.25% applies to the payment year 2026 and thereafter.

The potential MIPS incentives and penalties driven by the MIPS score are much more substantial than the inflationary adjustments. The following table shows the top-to-bottom Part B payment adjustment impact range in the initial program years:

MIPS Payment Adjustments: Maximum Impact Range

PERFORMANCE YEAR	MEDICARE PART B PAYMENT ADJUSTMENT YEAR	MAXIMUM -% MIPS PENALTY	MAXIMUM +% MIPS BASE INCENTIVE	MAXIMUM +% MIPS EXCEPTIONAL PERFORMANCE BONUS
2017	2019	-4%	+4%*X (Actual 0.29%)	+10%*Y (Actual 1.59%)
2018	2020	-5%	+5%*X (CMS predicts 0.30%)	+10%*Y (CMS predicts 1.75%)
2019	2021	-7%	+7%*X (CMA predicts 1.11%)	+10%*Y (CMS predicts 3.58%)
2020	2022	-9%	+9%*X	+10%*Y
2021	2023	-9%	+9%*X	+10%*Y
2022	2024	-9%	+9%*X	+10%*Y

**See explanation below. Assumes number of penalized clinicians is approximately equal to the number of clinicians earning incentives*

The maximum penalty increases to 9% of Part B payments beginning in the 2020 performance year. The maximum incentive is the sum of the maximum base incentive and the maximum exceptional performance bonus, which depend on respective scaling

factors, X and Y. We explain below how the predictions and estimates shown in the table were derived.

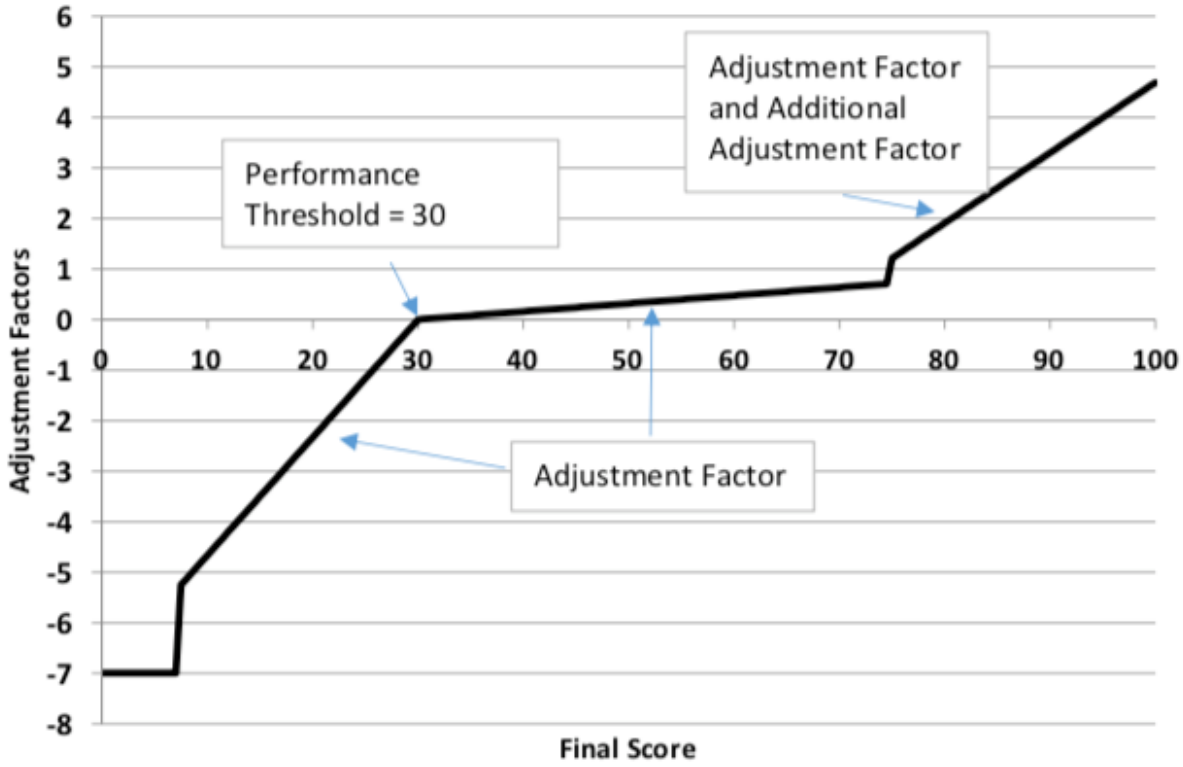
CMS calculates X (the "budget-neutrality factor") such that the national base incentive pool is set equal to the national penalty dollars assessed. Through this mechanism, those earning incentives are effectively being paid by those receiving penalties for substandard performance. For the 2022 performance year, CMS is required to configure the program such that about half of clinicians would be assessed penalties, making X ~ 1 and the maximum base incentive approximately +9%. X is capped at 3.0, such that the theoretical maximum base incentive for the 2020 performance year would be +9% * 3.0 = 27%.

CMS calculates Y by allocating $500M per year (available each year through 2022) to an exceptional performance bonus pool for high performers based on scoring rules described further below. As shown in the table above, CMS predicts Y = 0.358 for the 2019 performance year, yielding a maximum exceptional performance bonus of 3.58%. Furthermore, CMS predicts that 59% of 800,000 MIPS eligible clinicians (470,000 clinicians) will earn an exceptional performance bonus (minimum of 0.5% adjustment) for 2019 performance.

Due to the authority MACRA grants CMS to make it easier to avoid penalties for the initial 2017 and 2018 performance years, the 2017 maximum base plus exceptional performance incentive was lower than expected at 1.88%, and is predicted by CMS to be 2.05% for 2018 (references: 2017 MIPS feedback reports and 2018 QPP Final Rule). However, to prepare providers to reach the required ± 9% payment adjustment by the 2022 performance year, CMS is significantly increasing the difficulty of the program in 2019 such that the estimated maximum incentive is 4.69%, a 150% increase from that of 2017.

Translating MIPS Scores into Payment Adjustments

To illustrate the precise relationship between MIPS scores and Medicare Part B payment adjustments, the 2019 QPP Final Rule ("Figure 3") contains CMS' projection for how MIPS scores will translate into Medicare Part B payment adjustments for the 2019 performance year and associated 2021 payment year:



2019 QPP Final Rule, Figure 3, p1449

For each performance year, CMS sets a performance threshold (PT) number of points at which a provider earning PT points receives 0% adjustment to their Medicare Part B payments – no penalty, no incentive. As shown in Figure 3, CMS has set PT = 30 points for 2019. In the slanted parts of the adjustment line, every incremental tenth-of-a-point corresponds to a proportional change in payment adjustment. The maximum penalty is assessed if a clinician scores below ¼ of PT (equal to 7.5 points for 2019). On the other hand, if a clinician scores at or above the exceptional performance bonus threshold (EPBT; set to 75 for 2019, as seen in Figure 3), then the exceptional bonus is applied in proportion to the amount by which the MIPS score exceeds the EPBT.

The Bipartisan Budget Act mandates that CMS must gradually increase PT each year towards becoming the national historical mean or median in the 2022 performance year, which CMS estimates would likely be over 65 points (reference: 2019 QPP Final Rule, p1411).

To deliver a deeper understanding of the financial impact of MIPS as it applies to your unique environment, we provide a free MIPS financial calculator for analyzing the results of different scenarios and assumptions on predicted MIPS payment adjustments.

Reputational Impacts of MIPS

CMS publishes an array of clinician-identifiable performance measures through its Physician Compare website for consumers to browse and third-party physician rating websites to procure for free. As consumers spend more out-of-pocket for their healthcare, they are seeking more transparency into clinician quality and the cost-value equation. A study found that 65% of consumers are aware of online physician rating sites and that 36% of consumers had used a ratings site at least once[1]. In addition, 3rd-party consumer rating sites have found high correlations between revenues and consumer ratings. For instance, a 1-star difference on a 5-star rating scale on Yelp drives a 5% to 9% difference in service provider revenues[2] due to impacts on customer acquisition. For a given change in provider performance in a value-based program such as MIPS, this level of revenue impact due to the influence of publicly-reported scores on consumer choice can be much larger than that due to payer reimbursement variations[3].

MACRA requires CMS to publish each eligible clinician's annual MIPS score and performance category scores within approximately 12 months after the end of the relevant performance year. Consequently, more than half-a-million 2017 MIPS scores will be publicly available in early 2019, all identifiable by clinician and group. Third-party consumer websites will be able to access the data files containing scores and clinician ratings against national peers on a scale of 0 to 100. In addition, a 5-star rating scale will be applied to every MIPS quality measure for purpose of peer comparisons.

Although MIPS financial adjustments can change annually based on clinician performance, damage to a clinician's online public reputation may take years to reverse. Conversely, high publicly-reported scores can become a persistent strategic advantage over competitors.

The MIPS Score Follows the Clinician

The financial and reputational impacts stemming from the MIPS score are irrevocably attached to a clinician, even if the clinician changes organizations. If a clinician earns a MIPS score for 2018 and moves to another organization in 2019, the new organization will inherit the MIPS payment adjustment applied in 2020 based on the 2018 score earned by the clinician at the previous organization. This fact impacts how organizations should credential and contract with clinicians and may impact an organization's ability to attract the best and brightest if group scores are not competitive. In addition, every historical MIPS score earned by a clinician is a permanent part of the publicly-reported record released and maintained by CMS, effectively making MIPS scores an increasingly significant portion of a clinician's resume.

[1]JAMA, 2014; 311(7):734-735.

[2]The Impact of Online Reviews on Customers' Buying Decisions, July 2015

[3]The ABCs of MIPS: The Hidden Impacts of MIPS, May 18, 2017.

3. Who is subject to MIPS?

MIPS eligibility includes only those eligible clinicians in the categories below who bill for Medicare Part B (otherwise known as the Physician Fee Schedule) or Critical Access Hospital (CAH) Method II payments assigned to the CAH.
The eligibility net expands over the first several years as follows:

2017 and 2018 performance years: physicians (MD/DO and DMD/DDS), physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.

Additions for 2019 performance year: expanded to physical and occupational therapists, speech-language pathologists, audiologists, clinical psychologists, and registered dietitians or nutrition professionals.

Applicable payments for MIPS adjustments: For performance year 2019, Part B payments for services are subject to MIPS payment adjustments (excludes payments for items, such as Part B drugs).

Excluded Payments:
Medicare Part A
Medicare Advantage Part C
Medicare Part D
CAH Method I facility payments
Federally qualified health center (FQHC), rural health clinic (RHC), ambulatory surgical center (ASC), home health agency (HHA), hospice, or hospital outpatient department (HOPD) facility payments billed under the facility's all-inclusive payment methodology or prospective payment system methodology

Exclusions from MIPS

For the 2019 performance year, and for individual clinicians or groups of clinicians billing through a common tax identification number (TIN) meeting the above eligibility criteria, there are only three exclusions from MIPS:

Clinicians in their first calendar year of Medicare Part B participation
"Low-volume exclusion": in a 12-month period, clinicians or groups each (a) billing $90,000 or less in Medicare Part B allowed charges for services, (b) providing care for 200 or fewer Part B beneficiaries, or (c) delivering 200 or fewer covered services to Part B beneficiaries
Clinicians in entities sufficiently participating in an Advanced APM (see our APM FAQs)

Opt-in to MIPS

The 2019 performance year introduces a way for clinicians or groups subject to the low-volume exclusion (described immediately above) to still participate in MIPS and earn a payment adjustment. If one or two of the low-volume conditions (a), (b) or (c) is NOT met, then the clinician or group can opt in to MIPS.

MIPS APM Clinicians

Some clinicians who participate in an APM are also subject to MIPS. For example, Advanced APM clinicians not "sufficiently participating" in their APM entity are also subject to either standard MIPS or, if the APM design meets certain conditions deeming the APM a "MIPS APM", a special version of MIPS. A common example of a MIPS APM is the Medicare Shared Savings Program (MSSP), under which clinicians not assuming enough downside financial risk are also subject to MIPS scoring and reporting requirements. See our APM FAQs to learn more.

4. What determines a clinician's MIPS score?

A clinician's annual MIPS score of up to 100 points is determined by four categories of clinician performance and bonus point opportunities. See below for the 2019 performance year, and associated 2021 payment adjustment year:

Quality (45% weight, or 45 MIPS points maximum)
Cost (15% weight, or 15 MIPS points maximum)
Promoting Interoperability (PI) (25% weight, or 25 MIPS points maximum)
Improvement Activities (IA) (15% weight, or 15 MIPS points maximum)
Complex Patient Bonus (5 MIPS points maximum)

Should the total points earned be greater than 100 points, a 100-point cap would be applied. Under certain conditions, a clinician may be exempt from a performance category, which then triggers the available points from that category to be reallocated to one or more of the other categories. Note that re-weighting of categories occurs under these circumstances.

The MIPS score earned by a clinician for the performance year determines the percentage adjustment applied to every Medicare Part B service payment to the clinician in the payment adjustment year, which is the second calendar year after the performance year. About 7 months after the performance year ends, CMS delivers a MIPS feedback report to each clinician or group of clinicians that contains the official MIPS score calculated for that performance year.

Individual-Clinician Versus Group Scoring

For each performance year, a provider organization may choose to report MIPS data for clinicians individually or as a group of clinicians billing Part B through a common tax identification number (TIN). This decision must apply equally across all MIPS categories to determine a score for a given performance year, such that a clinician's score cannot be derived from individual reporting for some categories while from group reporting for the other categories. The decision to report as a group or by individual clinicians has financial and reputational ramifications that should be considered in association with the organization's culture and strategy.

Group Reporting:

Groups must consist of at least 2 clinicians who have assigned their Medicare Part B billing rights to the TIN, and at least one clinician must be individually eligible for MIPS Performance data for each category is aggregated across clinicians and submitted as a group. In contrast to individual reporting, group reporting dilutes the performance of individual over achievers and highlights measures more applicable to the group as a whole than to the specialty of any individual clinician.

Each TIN receives a single MIPS score, and every clinician billing Part B through that TIN inherits the group's MIPS score.

MIPS payment adjustments are applied to each TIN/NPI combination based on the group score.

An organization must submit data from all the clinicians in the group, including clinicians who are otherwise excluded from MIPS individually due to low volume, newly Medicare enrolled status, or Qualifying Participant (QP) status from an Advanced APM

Virtual Groups:

Practices each with up to 10 clinicians may together form a "virtual group" for the purpose of earning and submitting data for a collective MIPS score
The vast majority of MIPS group scoring rules apply to virtual groups
The deadline for applying to CMS to form a 2019 virtual group is/was December 31, 2018

Individual Reporting:

Each clinician is identified by a unique combination of national provider identification number (NPI) and the TIN through which the clinician bills Part B.

Clinicians billing through two different TINs receive two MIPS scores and separate payment adjustments for each TIN/NPI combination.

Submitting performance data by individual clinician emphasizes individual accountability, which may be preferred by specialty providers who want to differentiate themselves, or by organizations who are organizing in this way.

The choice of whether to report clinicians individually or as a group for MIPS can greatly affect the financial and reputational impacts of MIPS. For instance, the overall MIPS adjustment to an organization's Part B revenues can be dramatically different due to the ability to select unique quality measures under individual reporting, versus the same measures for all clinicians under group reporting. In terms of public reputation, individual reporting exposes a clinician's individually-earned MIPS score to consumers, whereas all clinicians inherit the same MIPS score under group reporting. The distribution of individual-clinician performance, organizational appetite for consumer transparency, and organizational culture all weigh into which option is best.

Note that clinicians also have the option to submit as a group and individually, with CMS attaching the higher of the two MIPS scores to that clinician. In this scenario, an

organization has the opportunity to benefit from the financial and public reporting aspects of individual high performers while still utilizing the benefits of group reporting for the remainder of the clinicians. However, more effort must be spent on performance monitoring and data submission for such "dual reporting". Automation can make dual reporting more practical and affordable. We help healthcare organizations work through and execute these decisions with IgniteMIPS. See how we make MIPS decisions easy in this video.

"Complex Patient" Bonus Points for the 2019 Performance Year

In the 2019 QPP Final Rule, CMS is recognizing risk factors incurred by clinicians for caring for complex patients: CMS will award up to 5 bonus MIPS points proportional to the level of clinical complexity and risk of a clinician's patient population. The bonus is based upon Hierarchical Condition Category (HCC) risk scores and socio-economic risk as measured based upon the proportion of patients with dual Medicare-Medicaid eligibility. CMS estimates the average complex patient bonus will be about 3 MIPS points.

Note that the complex patient bonus is granted only if data is submitted for at least one of the following MIPS performance categories: Quality, IA or PI; this bonus will not be granted if only the Cost category is scored.

Performance Category Re-Weighting

Under certain circumstances, such as a clinician qualifying for an exclusion from a single performance category, the scoring weights among the categories will be redistributed. For instance, the PI category may be re-weighted to 0% for clinicians claiming an EHR hardship exemption, in which case the entire 25% PI weight is shifted to the Quality category, resulting in a Quality category weight of 70% rather than 45%. For a complete list of re-weighting scenarios, see Table 54 in the 2019 QPP Final Rule, p1396.

5. How is the Quality performance category scored?

For the 2019 performance year, the Quality category is worth 45% of the MIPS score (except for category re-weighting scenarios described above). Each year, an eligible clinician or group selects one or more quality "collection types" to use for calculating quality performance. For example, the eCQM collection type uses the electronic clinical quality measures calculated by a certified EHR. Most collection types enable clinicians to select from an array of quality measures to report, whereas other collection types, such as CMS Web Interface, impose a predetermined set of measures.

Quality Collection Types

Each MIPS-eligible clinician or group of clinicians billing Part B through a common tax identification number (TIN) may choose from these quality collection types (2019 QPP Final Rule, p997-8):

For individual clinicians
eCQM
MIPS CQM (formerly known as qualified registry)
Qualified Clinical Data Registry (QCDR) measures
Medicare Part B claims measures (only for clinicians in small practices with up to 15 clinicians)

For groups or virtual groups:
eCQM
MIPS CQM (formerly known as qualified registry)
Qualified Clinical Data Registry (QCDR) measures
CMS Web Interface measures (groups of 25 clinicians or more)
Medicare Part B claims measures (only for small practices with up to 15 clinicians)
CMS-approved patient satisfaction survey vendor measure (CAHPS for MIPS)
Administrative claims measures (only for groups with at least 16 clinicians)

More details on these collection types can be found in the CMS QPP Resource Library, such as in the Quality Performance Category Fact Sheet. The quality performance period to be reported on is the full calendar year for all quality collection types.

In addition, in order to earn maximum quality points, each collection type requires reporting a minimum amount of data within the performance period to meet "data completeness" (2019 QPP Final Rule, p1011):

QCDR, MIPS CQM, and eCQM collection types require at least 60% of all-payer patients or visits qualifying for the denominator of each measure to be reported.

Medicare Part B claims requires at least 60% of Medicare Part B patients or visits.
CMS Web Interface requires at least 248 Medicare patients randomly selected by CMS to be reported upon for each measure.

CMS allows a clinician or group to select multiple collection types for each performance year. For instance, a group could choose eCQM and CAHPS for MIPS to derive its quality score. In the rare event that the same quality measure is reported using multiple collection types, then CMS will use the highest-scoring measure value in calculating the quality score.

CMS Web Interface and CAHPS for MIPS require registration with CMS by June 30, 2019 for the 2019 performance year. All other methods may be decided upon during the data submission period from January 1 to March 31, 2020, which is the first quarter following the performance year.

Quality Measures

There are approximately 300 MIPS quality measures, although typically only a subset of these are available to an organization based upon collection type and data sources, such as its EHR. Depending upon the collection type, different quality measures are available and required.

QCDR, MIPS CQM, eCQM and claims collection types require at least 6 measures to be selected, with at least one an outcome measure. If an outcome measure is not available, another "high priority" measure (appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related measure) can be reported.

A clinician may choose to report a specialty measure set, defined by CMS for a particular specialty. Should a specialty measure set contain fewer than 6 measures, then a clinician could meet the minimum reporting requirement by reporting all the measures in the measure set.

For groups and virtual groups consisting of at least 16 clinicians, CMS calculates and scores the administrative claims-based all-cause hospital readmission (ACR) measure, if there is a minimum of 200 cases in the denominator. Note that if no quality data is submitted using any other quality collection type, then the ACR measure is only calculated and scored for the Quality category if the clinician submits data for another MIPS category.

To explore the 2019 quality measures, see the CMS QPP website. If the QPP website has not yet been updated to show the final 2019 quality measure list, then consult Appendix 1 in the 2019 QPP Final Rule (p2168 – 2338) to review new, modified and deleted measures relative to the 2018 measure list.

Quality Scoring

Within the MIPS Quality category, each measure earns "measure achievement points". There is a total possible number of measure achievement points, termed the "total available measure achievement points", which varies depending upon the collection type. Each measure can earn up to 10 measure achievement points. For the QCDR, MIPS CQM, eCQM and Part B claims collection types, at least 6 measures of your choice must be selected, yielding 60 total available measure achievement points. If more than 6 measures are submitted, CMS scores the highest-scoring six. For CMS Web Interface, 9 mandatory measures are required (reduced from 14 measures for 2018), giving 90 total available measure achievement points. For a group with at least 16 clinicians and meeting the minimum number of cases for the ACR measure, CMS automatically calculates ACR and adds 10 additional points to the total available measure achievement points.

The "achievement percent score" is the total measure achievement points earned across the required number of measures divided by the total available measure achievement points. For example, if a clinician reports 6 measures using the eCQM collection type and earns 7 out of 10 measure achievement points for each measure, then the achievement percent score would be: (6 measures x 7 points) / (6*10) = 42 / 60 = 70%.

Each measure earns up to 10 measure achievement points on a peer-percentile benchmark scale based on measure performance rate (= measure numerator / denominator). Each reporting method will have a different set of measure benchmarks for the measures reported through that method. It is common for the same clinical measure to have different benchmarks for different reporting methods. The baseline period for deriving benchmarks is generally two years prior to the performance year.

For example, if a measure has a 62% measure performance rate that is better than 60% of peers reflected in the benchmark, then that measure would earn 7.0 out of 10 possible points, according to this illustrative measure benchmark table:
Example of Quality Benchmarks for a Single Measure to Assign Measure Achievement Points

DECILE	MEASURE PERFORMANCE RATE	RANGE OF MEASURE ACHIEVEMENT POINTS
Decile 1	0 – 6.9%	3.0
Decile 2	7.0 – 15.9%	3.0
Decile 3	16.0 – 22.9%	3.0 – 3.9
Decile 4	23.0 – 35.9%	4.0 – 4.9
Decile 5	36.0 – 40.9%	5.0 – 5.9
Decile 6	41.0 – 61.9%	6.0 – 6.9
Decile 7	62.0 – 68.9%	7.0 – 7.9
Decile 8	69.0 – 78.9%	8.0 – 8.9
Decile 9	79.0 – 84.9%	9.0 – 9.9
Decile 10	85.0 – 100%	10

For performance year 2019, note that there is a 3-point floor for scored measures meeting data completeness and case minimum requirements, as reflected in the above example table.

Quality measure benchmarks are topping out as performance improves, rendering some of the more common measures to yield less than 10 points. According to the 2018 benchmark file available in the QPP Resource Library, 24% (195/829) are topped out and at risk for maximum 7 points for 2019 performance. In addition, not all clinicians can contribute to MIPS in the same way. For example, cardiologists will perform better on measures relevant to their practice, whereas primary care clinicians will perform well on others. When selecting measures for your organization or for individual clinicians it is important to do it in the context of your broader quality improvement goals and objectives you've set out for the year. MIPS can be a motivator for positive change if it's strategically aligned. Watch this video to see how you can use MIPS as a change enabler for value-based care.

Bonus points can be earned in the Quality category by reporting multiple high priority measures, reporting quality data using end-to-end electronic reporting, by showing improvement from the prior performance year, or by virtue of being in a small practice.

High Priority Measure Bonus Points:

"High priority measure bonus points" are added to the measure achievement points when an additional high priority measure is reported beyond the required outcome measure or other high priority measure for the QCDR, MIPS CQM, eCQM and claims collection types. For instance, an additional outcome measure earns 2 bonus points. There is a cap on the total accumulated high priority measure bonus points of up to 10% of the total available measure achievement points. With 60 measure achievement points available, the high priority measure bonus cap is 6 points.

End-to-End Electronic Reporting Bonus Points:

There is a bonus of 1 point for each quality measure submitted with end-to-end electronic reporting (such as via the eCQM collection type), up to a category-wide bonus cap of 10% of the total available measure achievement points.

Small Practice Bonus:

Clinicians in a small practice with 15 or fewer clinicians will automatically receive 6 bonus points in the Quality category (2019 QPP Final Rule p1305-6) if data for at least 1 quality measure is submitted. CMS will notify organizations of their small practice status for the 2019 performance year by early 2019 through the CMS QPP portal.

Improvement Percent Score:

Additional points can be earned for improvement in the Quality category achievement percent score from the prior performance year.

"Improvement percent score" (up to a 10% cap) = 10% x (increase in achievement percent score from prior performance year) /(prior performance year achievement percent score).

The 10% cap is reached when the performance year's achievement percent score is double that of the prior performance year.

A floor of 30% is applied to the denominator in the above formula to avoid unduly rewarding clinicians who score lower than 30% in the 2018 Quality category due to reporting minimal data.

The total Quality performance category percent score is then calculated from the above components (total measure achievement points, total measure bonus points, improvement percent score):

“Quality performance category percent score” = [(total measure achievement points + total measure bonus points) / (total available measure achievement points)] + improvement percent score.

For example, assume a clinician reports 6 measures using the eCQM collection type and earns:
7 out of 10 measure achievement points for each measure,
4 bonus points for reporting 2 additional outcome measures,
2 bonus points for submitting two measures via end-to-end electronic reporting, and
a 5% improvement percent score.
The Quality performance category percent score would be: ((6*7) + 4 + 2) / (6*10) + 5% = 48 / 60 + 5% = 85%

If the category percent score were to exceed 100%, then it would be capped at 100%.

The formula to translate the Quality performance category percent score into a MIPS score contribution is:

Quality category MIPS points = (quality performance category percent score) x (quality category weight) x 100 MIPS points.

If no category re-weighting occurs such that the Quality category weight is 45%, then extending the above example yields: Quality category MIPS points = 85% x 45% x 100 = 38.3 MIPS points. Each tenth of a MIPS point impacts the payment adjustment.

Conditions Limiting the Measure Achievement Points

For the 2019 performance year, any of the below conditions may reduce the number of measure achievement points below what a quality measure would earn based upon its performance rate (2019 QPP Final Rule Table 50, p1284):

Not reporting for the full performance year: assigned 0 out of 10 measure achievement points

Not meeting data completeness: if in a small practice with 15 clinicians or fewer, assigned 3 points; otherwise, assigned 1 point.

Not meeting the measure’s case minimum (e.g., a denominator of 20): assigned 3 points (does not apply to CMS Web Interface).

No measure benchmark exists: assigned 3 points (does not apply to CMS Web Interface)
Measure is topped-out and thereby subject to special scoring: capped at 7 points; “topped-out” means that the national median performance rate is so high as to limit the utility of the measure in meaningfully differentiating performance between clinicians, e.g. a process measure with a national median performance rate of 95% or higher. The list of quality measures subject to topped-out scoring will be available in the 2019 performance year quality measure benchmark file by early 2019 in the CMS QPP Resource Library. CMS anticipates for the 2019 performance year that many more

measures will be subject to topped-out scoring than in past years, impacting an organization's ability to maintain or achieve high MIPS scores.

6. How is the Cost performance category scored?

Cost for the 2018 Performance Year

For the 2019 performance year, the MIPS Cost category is weighted at 15% and therefore worth up to 15 MIPS points. Cost measures are calculated using claims, not requiring clinicians to separately report data:

Total Per Capita Cost (TPCC) measure – The TPCC measure calculates the average per-patient Medicare Part A and Part B allowed charges (cost to Medicare plus co-pay and co-insurance charges to patients) for patients attributed to a clinician or group of clinicians (identified by tax identification number or TIN). A clinician is identified by a combination of the national provider identification number (NPI) and the TIN the clinician bills through, i.e. a TIN/NPI combination. Attribution of a given patient is based upon which clinician or group, respectively, billed the most allowed charges for primary care services delivered to that patient.

Medicare Spending Per Beneficiary (MSPB) measure – The MSPB measure calculates the average per-hospitalization-admission Medicare Part A and Part B costs to Medicare (excludes patient co-pay and co-insurance charges) for hospitalization episodes attributed to a clinician or group of clinicians. Attribution of an episode is based upon which clinician or group, respectively, billed the most allowed charges for physician services delivered to the patient during the hospitalization.

Episode-based cost measures – Eight new measures (2019 QPP Final Rule Table 36 p1054) gauge the total Medicare Part A and B allowed charges of procedural episodes (e.g. screening colonoscopy) and acute inpatient medical condition episodes (e.g. pneumonia with hospitalization). Procedural episodes are attributed to each MIPS eligible clinician (as identified by TIN/NPI combination) who delivers a trigger service for the episode type. Acute inpatient medical condition episodes are attributed to each clinician who bills inpatient evaluation and management (E&M) claim lines during the hospitalization and does so under a TIN that collectively bills at least 30% of the E&M claims lines for that hospitalization. For both types of measures, the episodes attributed to a group TIN are those attributed to all of the TIN's individual clinicians as identified by TIN/NPI combinations.

Cost Scoring

The cost measures are scored in a manner similar to the quality measures, where each measure earns up to 10 measure achievement points via a peer-percentile benchmark scale based on measure performance rate. Unlike the Quality category, there is no improvement score, and there are no measure bonus points.
"Cost performance category percent score" = (total measure achievement points) / (total available measure achievement points).

For example, assume a clinician meets the minimum eligible cases for the TPCC, MSPB and two episode-based cost measures and earns:

7 out of 10 measure achievement points for TPCC,
5 out of 10 measure achievement points for MSPB,
4 out of 10 measure achievement points for episode-based measure X, and
8 out of 10 measure achievement points for episode-based measure Y.
The Cost performance category percent score would be: (7 + 5 + 4 + 8) / (4*10) = 24 / 40 = 60%.

Since a clinician or group could meet the minimum eligible cases for up to 8 episode-based cost measures, the 2019 cost score could be dramatically different as compared to 2018, for which only the TPCC and MSPB measures are scored.

The formula to translate the Cost performance category percent score into a MIPS score contribution is:

Cost category MIPS points = (cost performance category percent score) x (cost category weight) x 100 MIPS points
If no category re-weighting occurs such that the Cost category weight is 15%, then extending the above example yields: Cost category MIPS points = 60% x 15% x 100 = 9.0 MIPS points.

Cost for the 2020+ Performance Years

According to the Bipartisan Budget Act of 2018, CMS must move the Cost category weight to 30% by 2022. Accordingly, CMS states in the 2019 QPP Final Rule (p1045) that the intention is to increase the weight by 5% each year from 2019 to 2022 to reach the 30% target weight. In addition, MACRA requires that CMS develop new episode-based cost measures which account for a target of at least ½ of all national Medicare expenditures under Part A and Part B. In 2018, CMS released field-testing feedback reports to clinicians and groups who met the case minimums for additional episode-based measures, and more measures are undergoing field testing.

Gain early insight into MIPS Cost category performance and identify improvement levers relevant to your unique environment through analyzing available feedback data, such as CMS field-based testing reports for episode-based cost measures.

7. How are the Promoting Interoperability (PI) and Improvement Activities (IA) performance categories scored?

Promoting Interoperability (PI)

The 2019 MIPS PI category inherits measures from Stage 3 Meaningful Use (MU) and introduces new ones to gauge the level of data interoperability associated with EHR use. A clinician or group must use 2015 Edition Certified EHR Technology (CEHRT). The minimum performance period is a continuous 90-day period within the performance

year for all reported measures. The objectives and measures finalized for 2019 are in this table from the Final Rule:

2019 QPP Final Rule Table 41, p1151

A clinician earns up to 110 PI measure points as the sum of these components: Performance Points: Up to 100 total points from non-bonus measures, where each measure is worth 10, 20, or 40 measure points. Performance rates are scored on a static decile scoring scale where, for instance, a performance rate of 50% earns 5 points out of 10, 66% earns 7 points out of 10 (CMS rounds 6.6 points up to 7 points), and a performance rate of less than 5% would receive a score of 1 if at least one patient was reported in the measure's numerator. The Public Health and Clinical Data Exchange measures are scored as yes/no.

Bonus Measure Points: Up to 10 total bonus points can be earned for reporting two optional opioid-related measures worth 5 points each.

In addition, an annual security risk analysis must be reported in order score any points in the category. Claiming an allowed measure exclusion causes the measure's points to be shifted to a different measure. If a clinician does not report either a numerator of 1 or a "yes" for a required non-bonus measure or claim an exclusion for it, then the entire category would receive a score of 0.

PI Scoring

The total earned measure points are divided by 100 total available measure points to derive a PI performance category percent score. If the percent score is greater than 100%, then it is capped at 100%.

The formula to translate the PI performance category percent score into a MIPS score contribution is:

PI category MIPS points = (PI performance category percent score) x (PI category weight) x 100 MIPS points.

If the performance score = 90 points, bonus points = 5, and PI category weight = 25%, then: PI category MIPS points = (90 + 5)/100 x 25% x 100 = 23.75 MIPS points.

Note that though some MIPS-eligible clinicians are individually excluded from PI, such as hospital-based clinicians, nurse practitioners, physical therapists, occupational therapists, registered dietitians/nutrition professionals, and others, they may optionally report PI measures and objectives to be scored like other MIPS eligible clinicians. In addition, clinicians may be granted hardship exemptions from PI through an annual application process. For excluded and exempted clinicians, the PI category weight is set to 0% and shifted towards other performance categories per the MIPS re-weighting rules.

Organizations often report PI as a group, rather than for individual clinicians. Unless the group as a whole is exempt from PI (e.g. all nurse practitioners), CMS requires that

PI data for all MIPS eligible clinicians in the group be aggregated and submitted, including for clinicians who would otherwise individually qualify for PI exclusions and category re-weighting. In this way, group reporting may increase the number of clinicians whose PI performance matters and should be monitored.

With these significant changes to the PI category, healthcare providers must actively manage PI versus prior years when the category was much more flexible and expansive in measure options. CMS predicts an 11.5% drop in the national median MIPS score due, in part, to the changes to the PI category. We can help you understand the impact of PI changes to your MIPS score. Request a 2019 MIPS consultation.

Improvement Activities (IA)

The MIPS IA category gauges the extent to which a clinician or group of clinicians is engaged in activities to improve clinical practice or care delivery. Clinicians earn points by attesting a minimum consecutive 90-day performance period within the performance year for each reported activity; each activity may have a different 90-day period.

To explore the 2019 improvement activities, see the CMS QPP website. If the QPP website has not yet been updated to show the final 2019 activity list, then consult Appendix 2 in the 2019 QPP Final Rule ((p2360 – 2376) to review new, modified, and removed activities relative to the 2018 list.

Here are the ways to earn the maximum possible IA score:
Clinicians in small practices (15 or fewer clinicians), practices located in rural areas or geographic HPSAs, or non-patient facing clinicians must earn at least 20 activity points, whereas all other clinicians or clinician groups must earn at least 40 activity points to earn the maximum possible IA score.

The “IA performance category percent score” is calculated by dividing the total earned activity points by either 20 or 40 points, respectively. If the percent score is greater than 100%, then it is capped at 100%.

Clinicians earn activity points in the following ways:

Report any combination of medium-weight (10 points each) and/or high-weight activities (20 points each), or if a clinician participates in an APM such as the Medicare Shared Savings Program or the Oncology Care Model, then the clinician automatically earns 20 points or 40 points, as determined by CMS for the APM, or if a clinician is in a certified patient-centered medical home or comparable specialty practice, then the clinician automatically earns 40 points.

IA Scoring

The formula to translate the IA performance category percent score into a MIPS score contribution is:

IA category MIPS points = (IA performance category percent score) x (IA category weight) x 100 MIPS points. If the total earned activity points = 30 points, activity points

needed for max IA score = 40 points, and IA category weight = 15%, then: IA category MIPS points = (30/40) x 15% x 100 = 11.25 MIPS points.

8. What are MIPS data submission and audit requirements?

Data Submission

As discussed above for MIPS data submission and scoring, an organization may choose to report data for clinicians individually or as a group that bills through a common tax identification number (TIN). The choice is made consistently across all MIPS performance categories for either a clinician or a group for a given performance year. The choice may be changed annually.

Inclusive of the collection types for the Quality category, the following are CMS' summary tables for data submission options by MIPS performance category:

TABLE 32: Data Submission Types for MIPS Eligible Clinicians Reporting as Individuals

Performance Category/Submission Combinations Accepted	Submission Type	Submitter Type	Collection Type
Quality	Direct Log in and upload Medicare Part B claims (small practices)[1]	Individual or Third Party Intermediary[2] Individual	eCQMs MIPS CQMs QCDR measures Medicare Part B claims measures (small practices)
Cost	No data submission required[2]	Individual	-
Promoting Interoperability	Direct Log in and upload Log in and attest	Individual or Third Party Intermediary	-
Improvement Activities	Direct Log in and upload Log in and attest	Individual or Third Party Intermediary	-

[1] Third party intermediary does not apply to Medicare Part B claims submission type.
[2] Requires no separate data submission to CMS: measures are calculated based on data available from MIPS eligible clinicians' billings on Medicare claims. NOTE: As used in this rule, the term "Medicare Part B claims" differs from "administrative claims" in that "Medicare Part B claims" require MIPS eligible clinicians to append certain billing codes to denominator-eligible claims to indicate the required quality action or exclusion occurred.

TABLE 33: Data Submission Types for MIPS Eligible Clinicians Reporting as Groups

Performance Category/Submission Combinations Accepted	Submission Types	Submitter Type	Collection Type
Quality	Direct Log in and upload CMS Web Interface (groups of 25 or more eligible clinicians) Medicare Part B claims (small practices)[1]	Group or Third Party Intermediary	eCQMs MIPS CQMs QCDR measures CMS Web Interface measures Medicare Part B claims measures (small practices) CMS approved survey vendor measure Administrative claims measures
Cost	No data submission required[1,2]	Group	-
Promoting Interoperability	Direct Log in and upload Log in and attest	Group or Third Party Intermediary	-
Improvement Activities	Direct Log in and upload Log in and attest	Group or Third Party Intermediary	-

[1] Third party intermediary does not apply to Medicare Part B claims submission type.
[2] Requires no separate data submission to CMS: measures are calculated based on data available from MIPS eligible clinicians' billings on Medicare claims. NOTE: As used in this rule, the term "Medicare Part B claims" differs from "administrative claims" in that "Medicare Part B claims" require MIPS eligible clinicians to append certain billing codes to denominator-eligible claims to indicate the required quality action or exclusion occurred.

2019 QPP Final Rule Tables 32 and 33, p997-8

A submitter type is the entity that performs the data submission, which can be an individual clinician, a group of clinicians (an authorized person representing the group), or a third-party intermediary (such as a health IT vendor). The submission type is the physical mechanism used to perform the submission. Direct is a computer-to-computer submission, such as through an application programming interface provided by CMS. The login and upload processes allow a submitter to upload a data file through, say, the CMS QPP submission portal. The login and attest processes are when a submitter manually enters data. CMS Web Interface and Medicare Part B claims are their own submission types and collection types.

Each performance category may be reported using a different allowed combination of submission type, submitter type, and, for quality, collection type. For the 2019 performance year, the Quality category may be reported using multiple collection types, each for a subset of the measures being reported for that category. By being able to mix-and-match reporting methods and measures within one category, clinicians will have a greater effective choice of measures to report for a given performance year.
Data submission to CMS must generally occur between January 2 and March 31 of the calendar year following the performance year.

Clinicians participating in a MIPS APM have special rules governing MIPS data submission. For example, the MIPS Quality category will not require a separate data submission if CMS is already collecting quality data for the APM. See our APM FAQs to learn about special rules governing MIPS data submission.

Audit Requirements

MIPS is auditable by CMS for up to 6 years after the associated data submission. Annually, CMS will selectively audit clinicians and groups and require them to share primary source documents, such as patient medical records, within 45 days of request (2018 QPP Final Rule, p837-839); this is unchanged from 2018. You can download the CMS recommended data validation and audit documentation for all 2018 MIPS categories and measures and check the CMS QPP resource library website for updated guidance for 2019.

Some further guidance for different MIPS performance categories:

Quality – Past precedence with CMS PQRS audits indicates that it is important to retain archived EHR patient-level snapshots of the entire period of data reported upon. In addition, certain third-party intermediaries such as MIPS CQM vendors (aka "registries") and QCDRs are subject to annual CMS audit requirements which may involve the clinicians and groups they serve.

Cost – There are no separate auditing requirements apart from the usual auditability of the administrative claims upon which the cost measures are based.

Promoting Interoperability – Likely to be audited in the manner that Meaningful Use (MU) was audited in the past. Pay special attention to retaining documents supporting the annual IT security risk assessment applicable to the reporting period, as this was a common audit vulnerability under MU.

An important consideration for healthcare providers is to ensure their MIPS vendor provides the ability to easily and effectively capture audit and submission documentation for each year, as well as provide an easy to access archive in the event of an audit.

9. How is MIPS different in 2019 versus 2018, and how will it further change in 2020?

The 2019 QPP Final Rule confirms that CMS is increasing the rigor of the MIPS program in the 2019 performance year and continuing through 2022, when the performance threshold must be set equal to the national mean or median of MIPS scores nationally. In 2019, it will be harder to achieve a high score: CMS predicts the 2019 median score will be 78.72, an 11.5% drop from the median score of 88.97 for 2017 (2019 QPP Final Rule, p1411). CMS identifies some drivers for this drop: the PI category becoming more difficult, reduced points for topped-out quality measures, higher Cost category weight, and new episode-based cost measures. At the same time, the maximum possible MIPS incentives are expected to be much higher in 2019 due to a larger incentive pool and fewer clinicians sharing in those incentives.

2019 Versus 2018

Key changes from 2018 to 2019, some of which we have covered elsewhere in these FAQs, include:

MIPS performance threshold raised from 15 points to 30 points out of 100
Exceptional performance threshold raised from 70 points to 75 points
Expansion of eligible clinician types and allowing for low-volume clinicians to opt in
Redesign of Promoting Interoperability category scoring and required use of 2015 Edition CEHRT
MIPS Cost category weight increased from 10% to 15%, and Quality down from 50% to 45%
Eight new episode-based cost measures
Introduction of facility-based MIPS scoring for quality and cost, which enables hospital-based clinicians to more easily earn a MIPS score through their hospital's performance in the Hospital Value-Based Purchasing (VBP) program
Removal of PI bonus points for reporting certain activities in the IA category
Removal of Quality bonus points for the CMS Web Interface collection type
Anticipating more topped-out quality measures with capped scoring
You can find additional differences between 2018 and 2019 in the CMS Fact Sheet for the 2019 QPP Final Rule.

Further Changes for 2020 and Beyond

MIPS is a catalyst to move healthcare providers toward value-based payment models. The 2019 QPP Final Rule signals additional changes in the coming years that will further amplify the program:

Continuing to increase the performance threshold by about 15 points per year, towards being above 65 points by 2022
Continuing to increase the Cost category weight by 5% per year, towards 30% by 2022, as required by law
Adding more episode-based cost measures
Removing quality bonus points for high-priority measures and end-to-end electronic reporting
Reducing bonus measures in the PI category
Access the ABCs of the QPP webinar replay where we dive into the details of the 2019 QPP Final Rule Changes and Imphttps://saigniteinc.wpengine.com/2019-mips-final-rule-changes-and-impactsact.

10. How does an organization sustainably succeed on the MIPS path?

Leadership and organization-wide commitment toward continuous performance improvement is critical to success in MIPS and in the transition to value-based care. As the financial stakes increase, the program gets harder, and scores become public, healthcare organizations will need to have effective insights to set meaningful goals, relevant scorecards to engage clinicians, and accurate data to manage performance.

Materially improving quality and cost performance in healthcare requires a multi-year MIPS success plan that includes key activities and decisions such as these:

Understanding where you stand today with MIPS and how changes in 2019 will impact your scores, months ahead of the 2018 MIPS feedback report (released by CMS in mid-2019).

Educating leaders about the evolution of MIPS over the next 2 years and the resource changes required to position the organization for success.

Managing MIPS PI category performance to ensure clinicians are on track for the mandated measures that are now available.

Relating the MIPS program to your other VBC or quality improvement initiatives to gain efficiencies, improve overall performance and maximize financial impact.

Making informed programmatic decisions about MIPS submission by understanding the impact to your scores and financial reimbursement.

Strengthening or establishing a continuous performance improvement discipline among clinicians catalyzed by MIPS, and extensible to other value-based programs.

Creating a multi-year QPP roadmap that includes your participation in MIPS and APMs and that is relevant to your organizational goals.

CMS References

CMS QPP website
CMS QPP Resource Library website (also linked to by the CMS QPP website)
2019 QPP Final Rule in the Federal Register
2019 QPP Final Rule – public inspection version (generally easier to read and annotate this PDF)
CMS 2019 QPP Executive Summary
CMS 2019 QPP Fact Sheet (table comparing 2019 QPP/MIPS to 2018)