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CLIENT ALERT

MIPS Performance Scoring: Understanding How CMS Proposes to Calculate Performance Is Key to Preparing for MIPS Participation

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On May 9, 2016, the Centers for Medicare & Medicaid Services ("CMS") published a proposed rule[1] addressing the implementation of physician payment reforms included in the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA").[2] This proposed rule defines how CMS intends to shift traditional fee-for-service payments that reward physicians for the volume of services delivered to patients to payments that reward value and patient outcomes under the new "Quality Performance Program" (the name that CMS has given to its framework for implementing the MACRA-mandated physician payment reforms). Comments on the proposed rule are due no later than 5 p.m. (EDT) on **June 27, 2016**.

CMS expects that only about 10 percent of physicians and other clinicians will be eligible for bonus payments for participation in an Advanced Alternative Payment Model ("APM") in the first years of the Quality Performance Program. Accordingly, most clinicians will be subject to payment adjustments beginning in 2019 based on performance under the new Merit-Based Incentive Payment System ("MIPS"). This Client Alert provides more details about how CMS proposes to score physician performance under MIPS. For an overview of the entire proposed rule, please see the recent Epstein Becker Green Client Alert titled "MACRA Proposed Rule: CMS Provides Details on Implementing Medicare's New Quality Payment Program."[3]

Importantly, these payment adjustments, which will begin in 2019, will be based on clinician performance starting in 2017. Therefore, the time for clinicians to engage in these improvement efforts is now. The final rule is expected to be released on or about

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[1] 81 Fed. Reg. 28,161 (May 9, 2016), *available at* www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentivepayment-system-mips-and-alternative-payment-model-apm.

[2] Pub. L. 114-10 (enacted Apr. 16, 2015).

[3] This Client Alert is available at http://www.ebglaw.com/news/macra-proposed-rule-cms-provides-details-on-implementing-medicares-new-quality-payment-program/.

November 1, 2016, so clinicians should not wait to see if the final rule will differ significantly.

In preparing for MIPS participation, clinicians should assess their current performance under the existing physician quality programs that will be rolled into MIPS (including the Physician Quality Reporting System, the Value Modifier, and the Medicare Electronic Health Record ("EHR") Incentive Program (known as "Meaningful Use" or "MU")), identify the quality measures and activities that are available under MIPS, and understand the scoring methodology in order to determine how to optimize MIPS performance.

MIPS Overview: Financial Incentives to Report Under MIPS

Beginning in 2019, MIPS eligible clinicians[4] will receive a positive, neutral, or negative payment adjustment based on how their performance on MIPS-reported measures and activities compares to a baseline performance threshold. The applicable percentage adjustments for each year are as follows: 4 percent for 2019, 5 percent for 2020, 7 percent for 2021, and 9 percent for 2022 and beyond. Positive adjustments must be paid out in an amount equal to the total negative adjustments made to clinicians. Accordingly, MACRA allows for the application of a scaling factor to the positive adjustment percentages of up to three times if the full scaling factor is applied. That means positive adjustments could reach up to 12 percent in 2019, 15 percent in 2020, 21 percent in 2021, and 27 percent in 2022, provided that the aggregate negative adjustments generate sufficient funding. There is also an additional payment adjustment of up to 10 percent possible for "exceptional" performers.

These financial incentives are expected to encourage MIPS eligible clinicians to engage in proven improvement measures and activities that impact health care quality, efficiency, and patient safety and are relevant for their patient population.

Summary of MIPS Performance Categories

A clinician's performance under MIPS will be based on the reporting of quality measures and activities related to four performance categories: Quality, Resource Use, Clinical Performance Improvement Activities ("CPIA"), and Advancing Care Information. The proposed rule addresses quality measures available for MIPS reporting in 2017, including existing measures, measures that do not require data submission, cross-cutting measures submitted via claims, registry and EHR, new measures, specialty measure sets, measures to be removed, and measures with substantive changes.[5] The

[4] "MIPS eligible clinicians" for 2019 include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such professionals. Clinicians who are in their first year of Medicare Part B participation, who are Qualifying APM Participants ("QP") or Partial Qualifying APM Participants ("Partial QP") who do not report on MIPS measures and activities, or who treat a "low volume of Medicare beneficiaries" (defined as Medicare billing charges of less than or equal to $10,000 and providing care for 100 or fewer Part B beneficiaries) are not "MIPS eligible clinicians."

[5] *See* Appendix, Tables A-G, 81 Fed. Reg. at 28,399-569.

proposed rule also defines and seeks comments on a proposed inventory of CPIA activities and the scoring weights associated with each activity.[6]

Clinicians may submit information using any of multiple mechanisms, as described in the table below. However, clinicians must use the same identifier[7] for all performance categories. Clinicians may use only one submission mechanism per performance category (e.g., a clinician cannot submit three quality measures via claims and two quality measures via registry).

Performance Category	Weight (Year 1)*	Maximum Possible Points	Assessment	Submission
Quality	50%	80 to 90 points, depending on group size	Six measures, including one cross-cutting measure and one outcome measure (or another high-priority measure if outcome measure is unavailable)	➢ Qualified Clinical Data Registry ("QCDR") ➢ Qualified registry ➢ EHR ➢ Administrative claims (no submission required) ➢ Claims ➢ CMS Web Interface (groups of 25 or more) ➢ CAHPS for MIPS survey
Resource Use	10%	Average score of all cost measures that can be attributed	All available measures, from 40 episode-specific measures, as applicable to the clinician	➢ Administrative claims (no submission required)

[6] *See* Appendix, Table H, 81 Fed Reg. at 28,570-86.

[7] CMS proposes to use an individual's or group's Medicare enrolled Tax Identification Number ("TIN"), which could be a Social Security number or Employer Identification Number, and the individual clinician's National Provider Identifier ("NPI") as identifiers under MIPS.

Performance Category	Weight (Year 1)*	Maximum Possible Points	Assessment	Submission
CPIA	15%	60 points	At least one CPIA activity, from a list of more than 90 options, with additional credit for more activities	➢ Attestation ➢ QCDR ➢ Qualified registry ➢ EHR vendor ➢ Administrative claims (no submission required) ➢ CMS Web Interface (groups of 25 or more)
Advancing Care Information	25%	100 points	Select measures based on six objectives for base score Select measures from the Patient Electronic Access, Coordination of Care Through Patient Engagement, and Health Information Exchange objectives for performance score	➢ Attestation ➢ QCDR ➢ Qualified registry ➢ EHR vendor ➢ CMS Web Interface (groups of 25 or more)

**CMS seeks comments on how to redistribute performance category weights if a clinician does not receive a Resource Use or Advancing Care Information performance category score.*

How Will CMS Convert Measure Reporting and Activities into Performance Scores?

CMS proposes a unified, composite performance scoring system to keep the scoring as simple as possible. The following characteristics are suggested to be incorporated into the proposed scoring methodologies for each of the four performance categories:

- For the Quality and Resource Use performance categories, each measure would be scored using a 10-point scoring system, with comparisons to historical benchmarks (if available) to assess improvement.

- Performance at any level would receive points towards the performance category scores.

- CMS is not looking to include an "all or nothing" reporting requirement for MIPS, but clinicians who fail to report on an applicable measure or activity will receive the lowest possible score of zero points.

- CMS will consider risk factors in the development of the scoring methodologies, and the agency will use measure-specific risk adjustment for all measures (where applicable) included in the Quality and Resource Use performance categories for the first year of MIPS.

- The measure and activity performance standards would be published, where feasible, before the performance period begins.

- The scoring proposals offer incentives to invest and focus on certain measures and activities that meet high-priority goals.

Scoring the Quality Performance Category

CMS proposes assigning one to 10 points for each measure based on how a MIPS eligible clinician's performance compares to specific benchmarks. The benchmarks would be determined based on performance measures in the baseline period and would be published prior to the performance year, if possible. Clinicians must report a minimum of 20 cases for all quality measures, with the exception of the all-cause hospital readmission measure, which has a minimum of 200 cases. For clinicians who are unable to meet the case minimum requirement (such as solo practitioners), CMS offers various scoring exceptions to ensure that their quality performance scores are not unfairly skewed.

To incentivize clinicians to report high-priority measures (outcome, appropriate use, patient safety, efficiency, patient experience, and care coordination measures), CMS proposes providing two bonus points for each outcome and patient experience measure reported and one bonus point for other high-priority measures that are reported (in addition to the already required one high-priority measure). Clinicians will receive bonus points only if the performance rate is greater than zero, and CMS proposes capping bonus points for high-priority measures at either 5 percent or 10 percent of the denominator of the quality performance score to prevent clinicians from using bonus points to mask poor performance.

CMS proposes providing an additional bonus point under the quality performance measure to incentivize clinicians to use certified EHR technology ("CEHRT"). To be eligible for the CEHRT bonus, the following requirements (known as "end-to-end electronic reporting") must be met:

- The MIPS eligible clinician uses CEHRT to record the measure's demographic and clinical data elements.

- The MIPS eligible clinician exports and transmits the measure data electronically to a third party.

- The third party, such as a registry, uses automated software to aggregate the measure data, calculate measures, perform any filtering of measurement data, and submit the data electronically to CMS.

The CEHRT bonus would be capped in a manner similar to the cap for the high-priority measures bonus, and CMS seeks comments on whether a 5 percent or 10 percent cap is appropriate.

In terms of measuring improvement, CMS has proposed three options:

- the approach currently used for the Hospital Value-Based Purchasing Program, where CMS assigns one to 10 points for achievement and one to nine points for improvement for each measure;

- the approach currently used for the Medicare Shared Savings Program, where clinicians would receive a certain number of bonus points for the quality improvement category for improvement; and

- an approach similar to that for assessing improvement for the Medicare Advantage five-star rating methodology, where clinicians would receive an overall "improvement measure score" by comparing the underlying numeric data for measures from the prior year with the data from measures for the performance period.

Scoring the Resource Use Performance Category

Scoring for the Resource Use performance category is analogous to the scoring for the Quality performance category, including assigning one to 10 points to each measure based on a clinician's performance compared to a benchmark and requiring a 20-case minimum for each resource use measure. The benchmark for the Resource Use performance category will be based on the performance period, unlike the use of a baseline period for the Quality performance category.

Scoring the CPIA Performance Category

Due to CPIA being a new performance activity with no ability to compare a clinician's performance to baseline data, CMS has proposed assigning points for each reported activity within two categories: medium-weighted activities (worth 10 points) and high-weighted activities (worth 20 points). High-weighted activities are specific activities related to:

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety and Practice Assessment
- Achieving Health Equity
- Integrated Behavioral and Mental Health

Any activity not listed as a high-weighted activity is considered to be a medium-weighted activity. For small practices, clinicians in rural areas or Health Professional Shortage Areas, or non-patient-facing clinicians, CMS believes that performing at least two CPIA activities is achievable and proposes to award these clinicians 30 points for any activity selected.

For the calendar year 2017 performance period, CMS has proposed a highest potential score of 60 points. Clinicians participating in a patient-centered medical home or comparable specialty practice will receive the full 60 points. In addition, clinicians participating in an APM will earn a minimum score of one-half the highest potential score, or at least 30 points. This is one example of how CMS proposes to provide clinicians participating in APMs with certain advantages under MIPS that could help the clinicians achieve positive MIPS payment adjustments. Although CMS has set a high bar for clinicians to receive the 5 percent Advanced APM bonus payment, and not all clinicians who participate in an APM will meet the criteria for the Advanced APM bonus payment, CMS does want to encourage APM participation. CMS therefore proposes to align standards, when possible, between the two components of the Quality Payment Program (MIPS and Advanced APMs) in order to make it easier for clinicians to move between them. Additional information about APM participation will be provided in a future Client Alert.

Scoring the Advancing Care Information Performance Category

CMS proposes to score clinicians for both participation and performance using a "base score" and a "performance score" under the Advancing Care Information performance category. To earn points toward the base score (a total of 50 percentage points), providers must report the numerator and denominator (or yes/no statement, as applicable) for each of six objectives and their associated measures. Failure to meet any of the objectives would result in a base score of zero and an Advancing Care Information performance category score of zero.

The performance score (a total of 80 percentage points) is calculated based on performance on associated measures related to the Patient Electronic Access to Health Information, Coordination of Care Through Patient Engagement, and Health Information Exchange objectives.

Further, up to one bonus point is available for additional Public Health and Clinical Data Registry reporting. Measure reporting requirements are described in the table below.

Objective	Measure	Reporting Requirements
Protect Patient Health Information	Security Risk Analysis	➢ Required measure ➢ A clinician must be able to report "yes" to receive any score in the Advancing Care Information performance category
Electronic Prescribing	ePrescribing*	➢ Required measure ➢ Numerator/denominator reporting
Patient Electronic Access to Health Information	Patient Access	➢ Required measure ➢ Numerator/denominator reporting ➢ May be selected as a part of the performance score
	Patient-Specific Education	➢ Required measure ➢ Numerator/denominator reporting ➢ May be selected as a part of the performance score
Coordination of Care Through Patient Engagement	View, Download, and Transmit	➢ Required measure ➢ Numerator/denominator reporting ➢ May be selected as a part of the performance score
	Secure Messaging	➢ Required measure ➢ Numerator/denominator reporting ➢ May be selected as a part of the performance score
	Patient-Generated Health Data	➢ Required measure ➢ Numerator/denominator reporting ➢ May be selected as a part of the performance score
Health Information Exchange	Exchange Information with Other Physicians or Clinicians	➢ Required measure ➢ Numerator/denominator reporting ➢ May be selected as a part of the performance score
	Exchange Information with Patients	➢ Required measure ➢ Numerator/denominator reporting ➢ May be selected as a part of the performance score

Objective	Measure	Reporting Requirements
	Clinical Information Reconciliation	➢ Required measure ➢ Numerator/denominator reporting ➢ May be selected as a part of the performance score
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting**	➢ Required measure ➢ A clinician must be able to report "yes"
	Syndromic Surveillance Reporting	➢ Optional measure ➢ May receive up to one additional point (in total) for reporting to any additional data registries
	Electronic Case Reporting	➢ Optional measure ➢ May receive up to one additional point (in total) for reporting to any additional data registries
	Public Health Registry Reporting	➢ Optional measure ➢ May receive up to one additional point (in total) for reporting to any additional data registries
	Clinical Data Registry Reporting	➢ Optional measure ➢ May receive up to one additional point (in total) for reporting to any additional data registries

**If a clinician does not use e-prescriptions at all, the clinician can report a null value without any impact on the clinician's base score.*
***If a clinician does not perform immunizations, the clinician can report a null value without any impact on the clinician's base score.*

A clinician's base score, performance score, and bonus point (if applicable) are added together for a total of up to 131 points. If a clinician earns 100 points or more, then the clinician receives the full 25 points in the Advancing Care Information performance category. If the clinician earns less than 100 points, the clinician's overall score in MIPS declines proportionately.

Conclusion

The changes to the Medicare physician payment system enacted in MACRA are immense and complex. More than one million physicians, other practitioners, and medical suppliers receive Medicare payment under the Physician Fee Schedule, so these changes will have broad-reaching impact. CMS has made efforts to streamline and align quality measures and activities to make reporting under MIPS simpler. All stakeholders are encouraged to give CMS feedback on the proposed rule to help shape how the MIPS program is implemented.

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