**How Were 2019-2020 MIPS Scored?**

**Background**

Established by the MACRA of 2015, the Merit Incentive Payment System came into effect on Jan 1, 2017. MACRA requires CMS to implement the Quality Payment Incentive Program, with two participation tracks: MIPS and Advanced Alternative Payment (AAPM) Models.

**Eligibility and Reporting Requirements**

A provider is eligible to participate in MIPS if (1) he is a MIPS-eligible clinician type (including not just physicians but also physician assistants, nurse practitioners, registered dietitians, etc.) AND (2) meets the requirements below. If the type and requirements are not met, the provider is exempt from MIPS.

Requirements:

* **As an individual**: (1) be identified as an eligible type on Part B claims, (2) have been previously enrolled as a Medicare provider, (3) not be a Qualifying APM Participant (i.e. the other incentive track), and (4) exceed the low-volume threshold as an individual.
  + Low volume threshold: i. bill more than $90,000 for Part B covered professional services (allowed charges); ii. see more than 200 Part B patients; iii. and provide more than 200 covered professional services to Part B patient. **Individuals of eligible types exceeding this threshold must participate in MIPS.** 
    - Clinicians exceeding one or two of the three thresholds can elect to **opt-in** (and receive payment adjustment) or **voluntarily report** (but receive no payment adjustment). If they don’t exceed any threshold they can only voluntarily report.
* As a group: for a provider to be MIPS eligible as part of a group, he must satisfy (1)-(3) of the requirements for individuals, and (4) the group must be MIPS eligible. A practice is MIPS eligible if it exceeds the low-volume threshold and has at least one clinician satisfying (1)-(3).
  + If a practice is MIPS eligible, it **may** report for all clinicians in the practice as a group. The clinicians will receive a score based on the group’s reporting, unless a final score can be attributed to them from individual or APM Entity participation.
  + In practice, most practices choose to report as a group to relieve administrative burdens and increase chance of success.
* **In a MIPS APM**: a MIPS eligible APM must meet the following criteria: (1) the APM entity participates under an agreement with CMS; (2) the APM entity has 1 or more MIPS eligible clinicians on a Participation List; (3) the APM must base payment incentives on performance on cost/utilization and quality measures (at the APM entity or clinician level).
  + MIPS APMs are a subset of APMs. They could include AAPMs but also APMs that do not meet the criteria to become a AAPMs, such as risk-sharing.
  + Clinicians in a MIPS APM who are MIPS eligible may be scored using the APM scoring standards, designed to account for activities already required by the APM.
  + This lowers the reporting burden by aligning MIPS and APM requirements.

**Scoring**

MIPS (based on a 2019 documentation):

* Weights: 45% quality, 15% cost, 15% improvement activities, 25% promoting interoperability.
* **Extreme and Uncontrollable Circumstances** **Policy** can be applied for each performance category! The clinician or group’s application needs to be approved. These events include circumstances that:
  + Cause the clinician/group to be unable to collect info necessary to submit for a MIPS performance category.
  + Cause the clinician/group to be unable to submit info that would be used to score a MIPS performance category for an extended period, and/or
  + Impact normal processes, affecting their performance on cost measures and other admin claims measures.
  + COVID – but this is for individuals only.
* **Quality**: **select 6 from more than 250 available quality measures**, then collect and submit data for each quality measure. In addition to the submitted measure, groups with **16 or more eligible clinicians** will be scored on the All-Cause Hospital Readmission measure if they meet the case minimum of 200 patients. Groups may also be eligible for facility-based scoring.
  + Performance for each measure is assessed against a historical benchmark differentiated by collection type. Can earn points:
    - Earn 3-10 for measures that have a benchmark, except some measures capped at 7 points.
    - Earn 3 points for quality measures that meet data completeness requirements but do not have a benchmark or meet the case minimum
    - 1 point for measures that do not meet completeness requirements. Small group practices earn 3 points for these anyways.
  + Maximum points (denominator): 60 for individuals; 60 for small groups; 70 for bigger groups required to report readmission measure; 80 for CMS Web Interface measures; 90 and 100 for CMS Web Interface measures + additional things.
  + Bonus points:
    - Do not count towards the denominator when computing the category score.
    - Can earn bonus points if submit additional outcome/other high-priority measures beyond the 1 required.
    - 1 bonus point for each measure reported using Certified EHR Technology
    - Bonus points are capped at 10% of the quality category denominator.
    - A “small practice bonus” (15 clinicians or fewer) of 6 points is added to the Quality category.
  + Improvement scoring bonus: MIPS eligible clinicians can also earn up to 10 addition percentage point in Quality based on the rate of improvement in the category from the previous year. This is added to the final quality category score. Cannot be negative.
* **Cost**: CMS uses Medicare claims data to calculate cost measure performance. There are 10 MIPS cost measure, each giving 10 total possible points for a denominator of 100.
  + CMS compares each cost measure to a single, national benchmark.
  + Each measure has a different case minimum; the denominator is lowered by 10 for each measure for which the case minimum is not met.
  + Reweighting:
    - If a clinician can’t be scored on any measure, cost will be reweighted to zero.
* **IA**: Can earn up to 40 points by submitting between 1 and 4 improvement activities. The denominator cannot be lower than 40.
  + Clinicians and groups generally receive 10 points for medium-weighted activities, and 20 points for high-weighted activities. For example, to achieve the maximum, the clinician can pick 2 high-weighted activities or 1 high weighted activity and 2 medium activities.
  + Bonus points
    - Clinicians and groups with a (1) small practice designation (15 or fewer NPIs), (2) non-patient facing designation, (3) health professional shortage area or (4) rural designation earns 20 points for each medium-weighted activity and 40 points for a high-weighted activity!
    - Automatic 40 points if = a MIPS APM or a Patient-centered Medical Home.
* **PI**: Has a single required set of objectives and measures to report. Objectives include e-Prescribing, Health Info Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange.
  + Each objective is assigned a different maximum point adding up to 100. Denominator cannot be lower than 100.
  + There are also some additional requirements. One includes **using a 2015 Edition Certified EHR Technology to meet the measures above and collect the data.**
  + If any of the requirements or attestations are not met, **PI category score will be zero!**
  + Bonus points:
    - **5 bonus points** are given to each of these two bonus measures upon submission regardless of performance: Query of Prescription Drug Monitoring Program, and Verify Opioid Treatment Agreement (which is when the eligible hospital traces the existence of a signed opioid treatment agreement for patients electronically prescribed at least 30 cumulative days of opioid).
  + Reweighting:
    - PI category can be reweighted to zero (and have the 25% redistributed to Quality) if:
      * The clinician or group submits a **PI Hardship Exception Application** due to: insufficient internet connectivity, extreme and uncontrollable circumstances, lack of control over the availability of CEHRT, small practice, and decertified EHR.
      * Automatic reweighting if the clinician is a PA, NP, hospital-based clinician, ASC-based clinician, non-patient facing clinician, and some other health profession types.
      * The group qualifies for reweighting only if ALL of the MIPS eligible clinicians in it do.
      * If the hardship application is approved or automatic reweighting qualification is met, the clinician or group can still submit data for PI measures to have it be weighted at 25%.
* **Final Score**: weighted sum of all categories + Complex Patient Bonus.
  + Complex Patient Bonus: 0 to 5 points to the final score
    - Based on patients’ medical complexity (average HCC risk scores) and social risk (proportion of dual eligible status).
  + COVID & PY 2019-2020: <https://qpp.cms.gov/mips/exception-applications?py=2019>
    - If all four categories are reweighted to zero due to Extreme and Uncontrollable Circumstances Exception, the clinician/group will receive the minimum score (30 in 2019) for a neutral payment adjustment.
    - CMS reopened the MIPS EUC applications during COVID to groups and individuals who started but were unable to complete their data submission.
    - In 2019, if a clinician was MIPS eligible and did not submit any data by April 30, they **automatically** qualified the EUC policy.
      * If the MIPS eligible clinician is in a MIPS APM, she will receive the APM score even if she qualifies for automatic reweighting – her weight when computing the APM-level score will just be zero.
    - In 2020, all MIPS eligible clinicians automatically got all categories reweighted to zero, unless they submitted data for two or more performance categories. The automatic EUC policy did not apply to group, only individuals!

APM scoring standard (2019):

* Weights: 50% Quality, 30% Promoting Interoperability, 20% Improvement Activities, 0% Cost.
* All participants in a single MIPS APM will receive the same MIPS score.
  + **Quality**: the CMS uses the quality measured required by the APM itself. Quality measures are scored against the MIPS APMs’ benchmarks for those measured.
  + **PI**: scored at the APM Entity level, averaging the PI scores of all APM participants to get a score that applies to all.
    - If all MIPS eligible clinicians in an APM Entity have been excepted from reporting PI, this category will be reweighted to zero for the APM Entity.
  + **IA**: All MIPS APMs are automatically given a 40/40!
* Clinicians in two or more MIPS APMs will receive the highest final score to receive payment adjustment.