2017 MIPS Requirements

Final requirements for full participation in MIPS during the 2017 performance period

Quality

Eligible clinicians and groups must report 6 measures, including 1 outcome measure or, if an outcome measure is not available, 1 other high-priority measure (appropriate use, patient safety, efficiency, care coordination or patient experience).

- If the clinician cannot or does not report one or more of the required measures, he/she will be scored on the measures that are submitted.
- Clinicians can select from the CMS-approved list of all MIPS measures or can select a single set of specialty-specific measures. If the set includes more than 6 measures, clinicians can select any 6 that meet the above requirements.
- Measures reported via QCDR and Qualified Registry must include at least 50% of an eligible clinician or group's entire patient population, regardless of payer, and a minimum case volume is required for each measure.
- Groups of 16 or more who meet a minimum case volume will also be evaluated on 1 population measure, all-cause hospital readmissions (ACR), calculated from submitted Medicare Part B claims.

Cost

CMS will calculate Cost measures based on submitted Medicare Part B claims data, so there are no additional reporting requirements for clinicians and groups under this performance category.

- Clinicians and groups will be assessed on all measures applicable to them.
- Common measures applied to all individuals and groups include Medicare Spending per Beneficiary (MSPB) and Total Per Capita Costs for all attributed beneficiaries.
- For 2017, CMS has finalized 10 episode-based measures which will be applied based on applicability.
- Cost measures, which have case minimums of either 20 or 35, will be attributed to individual clinicians at the TIN/NPI level. For groups that participate in group reporting in other MIPS performance categories, Cost performance category scores will be determined by aggregating the scores of the individual clinicians within the TIN.

Advancing Care Information

The Advancing Care Information score replaces Meaningful Use and focuses on the secure exchange of health information and the use of certified EHR technology.

- The first component is called the "base score," for which eligible clinicians must report either "yes" (for yes/no measures) or a numerator of at least 1 (for numerator/denominator measures) for 5 measures included in the following objectives: Protect Patient Health Information, Electronic Prescribing, Patient Electronic Access, and Health Information Exchange.
- The second component is the "performance score," based on performance rates for selected measures in the following objectives: Patient Electronic Access, Patient-Specific Education, Secure Messaging, Health Information Exchange, Medication Reconciliation, and Public Health reporting.
- Clinicians/groups can also earn bonus points for reporting "yes" on measures associated with the Public and Clinical Data Registry Reporting objective or by reporting improvement activities using Certified EHR Technology.

Improvement Activities

The Improvement Activities performance category rewards eligible clinicians and groups for participating in and completing patient-centered activities that have a proven association with improved health outcomes.

- CMS has finalized over 90 activities designated as either high- or medium-weight. Clinicians must attest to completing a combination of these activities.
- Eligible clinicians/groups participating in certain patient-centered medical homes will receive full credit for this category, and Alternative Payment Model (APM) participants will receive at least 50% credit.
- Practices with 15 or fewer clinicians and practices located in rural areas and geographic health professional shortage areas need to attest to completing fewer activities in order to receive full credit.
- An improvement activity must be performed for at least 90 consecutive days during the performance period to earn credit in this performance category.

Able Health

Source: Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

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2017 MIPS Composite Score

Final methodology for calculating the MIPS Composite Score for individual clinicians and groups in the 2017 performance period

Quality — 60%

Between 1 and 10 points will be awarded based on performance against benchmarks for each submitted quality measure that meets the minimum case volume, up to 6 measures total.

- 2 bonus points are awarded for additional outcome/patient experience measures, and 1 bonus point is awarded for other high priority measures.
- 1 bonus point is available for each measure reported using Certified EHR Technology in end-to-end electronic reporting (up to 10%).
- During the 2017 transition year, a minimum of 3 points will be awarded for each submitted measure, regardless of performance.
- For groups of 16 or more with sufficient case volume, up to 10 additional points will be awarded for performance on the claims-based population measure, all-cause hospital readmission.

Cost — 0%

CMS will calculate Cost performance using submitted Medicare Part B claims for Per Capita Costs for all attributed beneficiaries, Medicare Spending Per Beneficiary (MSPB), and all applicable episode-based measure.

- For the 2017 transition year, performance results will be calculated and shared with providers but will not contribute to the 2017 composite score.
- The MSPB measure has a 35-case minimum, and all other measures have a 20-case minimum. If an individual clinician does not meet the minimum case volume, they will not receive a Cost performance category score.
- There are no bonus points available in this performance category.

Advancing Care Information — 25%

The performance category score is capped at 100 points (out of a possible 155 points) and consists of a base score plus a performance score.

- 50 points are available for the base score, which consists of reporting a numerator/denominator or yes/no statement for 5 measures. For numerator/denominator measures, clinicians must report at least a 1 in the numerator; for yes/no statement measures, clinicians/groups must report a "yes" for credit.
- 90 points are available for the performance score, which is determined based on the reported numerator and denominator for measures in 6 objectives: Patient Electronic Access, Patient-Specific Education, Secure Messaging, Health Information Exchange, Medication Reconciliation, and Public Health Reporting.
- 5 points are available for completing Public Health and Clinical Data Registry Reporting, and 10 points are available for reporting improvement activities using Certified EHR Technology.

Improvement Activities — 15%

To receive maximum credit, individual clinicians and groups of 15 or more eligible clinicians must achieve at least 40 points through completing a combination of high- and medium-weighted activities.

- 20 points are awarded for attesting to high-weighted activities
- 10 points are awarded for attesting to medium-weighted activities.
- Eligible clinicians and groups participating in an APM automatically receive half credit and can increase their total by reporting additional activities.
- Eligible clinicians and groups participating in a certified patient-centered medical home automatically earn full credit.
- Non-patient-facing clinicians, small practices with 15 or fewer professionals, and practices located in rural areas and geographic health professional shortage areas can achieve full credit with 1 high-weighted or 2 medium-weighted activities (20 points total).

Able Health

Source: Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

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