Merit-based Incentive Payment System (MIPS)

The SGR Repeal and Medicare Provider Modernization Act of 2015 established the Merit-based Incentive Payment System (MIPS) which will go into effect January 1, 2017. MIPS will combine several federal quality programs including the Physician Quality Reporting System (PQRS), Value-based Modifier (VM), and Medicare Electronic Health Record (EHR) incentive program (i.e., Meaningful Use) into a single quality payment system with escalating incentives and penalties.

MIPS is a single program in which eligible clinicians will be measured on four different areas:

- **Quality** (replaces PQRS)
- **Resource Use** (replaces the cost component of VM)
- **Clinical Practice Improvement Activities** (new)
- **Advancing Care Information** (replaces “Meaningful Use” of EHRs)

Each of these different areas will account for a specific percentage of the total score of 100%:

- **Quality** \( \rightarrow \) 50% of the total score in year 1
- **Resource Use** \( \rightarrow \) 10% of the total score in year 1
- **Clinical Practice Improvement Activities (CPIA)** \( \rightarrow \) 15% of total score in year 1
- **Advancing Care Information (ACI)** \( \rightarrow \) 25% of total score in year 1

The total percentage received out of 100% will be the clinician’s **Composite Performance Score** and will be used to compute a positive, negative, or neutral adjustment to Medicare Part B payments. The law requires that MIPS be budget neutral.

**MIPS Participation**

In the first two years of the MIPS program, a “MIPS eligible clinician” is defined as physicians (MD/DO and DMD/DDS), physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNS), and certified registered nurse anesthetists (CRNA).

The definition of “eligible clinician” under MIPS may expand in future years to include physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and/or dietitians/nutritional professionals.
There are three groups of clinicians who will NOT be subject to MIPS:

- Clinicians in their first year of Medicare Part B participation
- Clinicians that are below the low patient volume threshold (defined as Medicare billing charges less than or equal to $10,000 and providing care for 100 or fewer Medicare patients in one year)
- Certain participants in Advanced Alternative Payment Models

*Most clinicians will be subject to MIPS*

- Subject to MIPS
  - Clinicians not in an Advanced Payment Model (APM)
  - Clinicians in non-advanced APM
  - Clinicians in advanced APM, but who are not a Qualifying Physician (QP)
    - Some clinicians may be in an advanced APM, but do not have enough payments or patients through the advanced APM to be a QP

Eligible Clinicians can participate in MIPS as an:

- Individual; or
- Group
  - A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories

**MIPS Timeline**

2017
- First Performance Period (January 1st - December 31st)
- First Feedback Report (July)

2018
- Second Performance Period (January 1st – December 31st)
  - Reporting and data collection
- Analysis and Scoring of 2017 data
- Second Feedback Report (July)
- Targeted Review based on 2017 MIPS performance (July)

2019
- MIPS Payment Adjustments based on 2017 data take effect
MIPS Payment Adjustments

Based on the MIPS Composite Performance Score, clinicians will receive a positive, negative, or neutral adjustment up to a maximum adjustment. The potential maximum adjustment percentage will increase each year from 2019 to 2022.

- 2019 → +/- 4%
- 2020 → +/- 5%
- 2021 → +/- 7%
- 2022 → +/- 9%