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Measuring Provider Performance for Physicians Participating in the Merit-Based Incentive Payment System (MIPS)

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Abstract

In 2017 the Centers for Medicare and Medicaid Services (CMS) began requiring all eligible providers to participate in the Quality Payment Program (QPP) or face financial reimbursement penalty. The QPP outlines two paths for provider participation: the merit-based incentive payment system (MIPS) and advanced alternative payment models (APMs). For the first performance period beginning January 2017, CMS estimates that approximately 83–90% of eligible providers will not qualify for participation in an advanced APM, and therefore must participate in the MIPS program. The MIPS path replaces existing quality reporting programs and adds several new measures to evaluate providers using four categories of data: 1) quality, 2) cost/resource use, 3) improvement activities, and 4) advancing care information. These categories will be combined to calculate a weighted composite score for each provider or provider group. Composite MIPS scores based on 2017 performance data will be used to adjust reimbursed payment in 2019. In this article, we provide relevant background for understanding value-based provider performance measurement. We also discuss MIPS reporting requirements and scoring methodology to provide plastic surgeons with the necessary information to critically evaluate their own practice capabilities in the context of current performance metrics under the QPP.

Keywords

MACRA; Medicare; Value-Based Payment; MIPS; Provider Performance

Under the 2015 Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA), the Centers for Medicare and Medicaid Services (CMS)

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established the Quality Payment Program (QPP).¹⁻² The QPP requires all eligible Medicare Part B fee-for-service providers to participate in one of two paths evaluating value-based provider performance: the merit-based incentive payment system (MIPS) or advanced alternative payment models (APMs).² For the first performance period beginning in January 2017, approximately 83–90% of providers will not qualify for advanced APM participation and will be required to participate in the MIPS program or face financial reimbursement penalties in 2019.²⁻³ The MIPS program evaluates providers (or provider groups) using a composite score derived from four performance categories: 1) quality, 2) cost/resource use, 3) improvement activities, and 4) advancing care information.^{2,4} These performance categories replace existing quality reporting programs (physician quality reporting system, value-based payment modifiers, and meaningful use) and add several new measures to capture the value of care patients receive.⁴⁻⁵

In order to optimize performance in the MIPS program, plastic surgeons must have in-depth knowledge regarding MIPS reporting requirements and scoring methodology. In addition, plastic surgeons also need to understand the broader scope and direction of value-based payment reform to best prepare themselves for future changes in performance measurement and MIPS scoring algorithms. The purpose of this paper is to provide necessary and timely information regarding value-based performance measurement and MIPS scoring methodology. This information will enable plastic surgeons participating in the MIPS pathway to critically evaluate their own practice capabilities in the context of current performance metrics under the QPP.

Quality and Performance Measurement Background

The concept of value originated from economic theory and is mathematically equivalent to quality divided by cost ($\text{value} = \text{quality} \div \text{cost}$; Figure 1).⁶ Value-based payment reforms aim to increase value by either increasing quality without increasing cost, maintaining quality and decreasing cost, or a combination of both. However, integral to the success of value-based payment reform is the development of accurate and reliable ways to measure quality and cost.⁷

From the payer perspective, the costs associated with services or encounters are easily estimated in the form of reimbursed claims. However, developing judicious quality measures has been the topic of much research and debate. In 1966 Donabedian published a conceptual framework for evaluating health care quality that has served as the foundation for many quality and performance measures used today (Figure 1).⁸ This framework evaluates healthcare quality as the product of three different entities: structure, process, and outcome. Structure includes all the factors that affect the context in which care is delivered.⁸ Processes describe the sum of all actions that make up health care, and outcomes refer to the effects of healthcare on patients and populations.⁸

Outcome measures are the most familiar to providers and they evaluate patient health after receiving care. Without proper risk-adjustment, outcome measures assume that all observed effects are the result of the care provided and do not consider factors outside the health system.⁹ Traditional outcome measures frequently include tracking survival (e.g., mortality),

disease improvement/progression (e.g., diabetes control), complications (e.g., infection), and utilization (e.g., readmission). They have the benefit of being objective and easily understandable by patients and providers. However, outcome measures are often criticized for being rudimentary downstream consequences of various different complicated processes.⁹ These measures do not reflect the complete patient experience and thus do not fully describe quality. Furthermore, there is considerable debate regarding the proper risk adjustment or stratification methods required to accurately compare outcome measures across providers and hospitals.

Process measures are used to determine the extent to which providers give patients specific services that are aligned with recommended guidelines for care. These measures are generally linked to procedures or treatments that are known to improve health status or prevent future complications.⁹ Unlike outcome measures, process measures are unable to be influenced by factors outside the healthcare system. They are more practical to collect than outcome measures and provide opportunities for immediate actionable feedback to improve performance.⁹ Furthermore, the implementation of process measures within a health system has been shown to have a positive spillover effect raising clinician awareness about quality measures and clinical guidelines. However, process measures rely on clear evidence-based clinical guidelines for implementation and thus are not available for many areas of medicine.⁹

Structural measures evaluate the infrastructure of health care settings and their ability to deliver quality care. These measures include evaluations of staffing capabilities (e.g., ICU staffing and nursing work hours), available resources (e.g., electronic health records), and meaningful use (e.g., providing patients with timely electronic access to their health records).⁹⁻¹⁰ These measures are useful because they represent necessary elements for providing high quality care. However, they are often viewed as less valuable because they are the furthest removed from patient effects and improving outcomes.⁹ Structural measures only indicate the potential for providing high quality care, but do not ensure that the processes are in place to provide good outcomes.

As value-based provider performance continues to expand under MIPS, it is imperative for plastic surgeons to understand how each measure in every MIPS category relates to the value framework in Figure 1. This will enable plastic surgeons to best assess the strengths of their own practice and negotiate with health organizations to institute change that will facilitate better value of care delivered to patients and improve measured provider performance. The MIPS advancing care information category replaces the previous meaningful use program and includes measures that rely on structural electronic health record (EHR) capabilities to deliver high quality care and also evaluate the use of EHRs in care processes.^{2,4-5} The quality category replaces the previous physician quality reporting system and contains measures that evaluate all aspects of the value framework (outcomes, processes of care, structural capacity, and efficiency of resource use).^{2,4-5} Finally, the cost category replaces the previous value based modifier and will evaluate resource use through claims data.^{2,4-5} The new improvement activities category includes a combination of measures that evaluate whether or not the provider is undertaking efforts to improve the value of care (by improving quality and/or decreasing cost) they deliver to patients.² By viewing the MIPS value

measures in this framework, providers will have a better idea of measures that they are able to control more directly within the scope of their own practice and measures that rely more heavily on organizational and infrastructural support.

MIPS Performance Categories and Reporting Requirements

Table 1 provides an overview of each MIPS performance category and reporting requirements for the first performance period beginning January 2017.² For each category, there are specific groups of providers who have different reporting requirements than the general MIPS population depending on the organization and size of their practice (Table 1).² The following discussion focuses on reporting requirements for the general MIPS population. For the quality category, the majority of providers must select 6 measures, including 1 outcomes measure, to receive credit for full participation in the 2017 performance period. Each medical specialty has worked with CMS to define a list of measures that are most relevant to providers in their specialty. However, providers are not restricted to measures in this set and may select any of the other available individual quality measures if they are more relevant or more accurately reflect provider performance.¹¹ Table 2 lists and describes the 11 quality measures contained in the plastic surgery measure set. All of these measures, except for surgical site infection, are process measures that evaluate whether or not plastic surgery providers deliver care in line with established guidelines.

For the advancing care information category, the majority of providers will be required to fulfill 5 measures for a minimum of 90 days (Table 1).² First, they must conduct or review a security risk analysis to protect patient health information and implement security updates and correct identified security deficiencies as part of the MIPS eligible clinicians risk management process. Second, at least one permissible prescription must be queried for a drug formulary and transmitted electronically using certified EHR technology. Third, at least one unique patient must be provided with timely access to view online, download, and transmit his or her health information using certified EHR technology. Fourth, for at least one transition of care or referral, the referring MIPS provider must create a summary of care using certified EHR technology and electronically exchange the summary of care record. Finally, for at least one transition of care or referral, the receiving MIPS provider (who has never encountered the patient before) must retrieve and incorporate an electronic summary of care document into the patient's record. Providers may receive an additional bonus for reporting additional measures, reporting registry data, or if they use certified EHR records to complete certain activities in the improvement activities category.²

For the improvement activities category, providers must complete 4 out of 92 activities for a minimum of 90 days to receive credit for full participation (Table 1).² Measures in this category include activities that evaluate whether or not the provider is engaging in efforts to improve the quality of care (structure, process, or outcome) or reduce the cost of care they deliver. They are divided into 8 subcategories: 1) achieving health equity, 2) behavioral and mental health, 3) beneficiary engagement, 4) care coordination, 5) emergency response and preparedness, 6) expanded practice access, 7) patient safety and practice assessment, 8) population management.² Many of these activities require participation and buy-in from the managing organization of a healthcare system and will be difficult for many independent

plastic surgeons to fulfill on their own without infrastructural or organizational support. Plastic surgeons in all settings will need to evaluate their capacity to work within their organization and/or coordinate with referring practices to satisfy measures that are most amenable to their own specific practice setup.

Steps to Determining the MIPS Payment Adjustment

CMS has outlined 6 steps to determining the MIPS payment adjustment (Figure 2).¹² For the first performance period in 2017, providers will be required to submit data by March 31, 2018.^{2,5} Providers may choose the “pace” for their transition into the QPP by submitting data anytime between January 1, 2017 and October 2, 2017.^{2,5} Based on the quantity and duration of data submitted, providers will be designated into non-participation, test-participation, partial-participation, and full-participation categories that will determine their eligible adjusted payment.^{2,5,13} CMS estimates that category scoring and composite MIPS performance scores will be calculated by mid 2018.^{5,12} Payment adjustment determination (based on the composite MIPS score) will be conducted in 2018 with application of adjusted payments on January 1, 2019.^{2,15}

Step 1: Data Submission

On September 26, 2016, CMS released the annual Quality and Resource Use Reports (QRUR) for each group or solo practice Medicare-enrolled taxpayer identification (TIN) evaluating their 2015 performance.¹⁵ Providers may access their reports on the CMS portal to prepare for MIPS participation and inform the “pace” of their transition into the QPP.^{15–16} Prior to submitting data to CMS, providers must choose whether they would like to participate in MIPS as an individual or as part of a group. If clinicians participate as a group, they must reassign their billing rights to a single TIN and they will be assessed jointly across all four MIPS categories (i.e., receive a single MIPS composite performance score).^{2,15} Table 3 outlines the options for groups and individuals to submit data for each MIPS performance category.¹⁵ The use of third party intermediaries, such as EHR vendors, qualified clinical data registries (QCDRs), and consumer assessment of healthcare providers and systems (CAHPS) vendors, requires certification and approval by CMS but does not cost require any financial investment from clinicians.¹⁵

Step 2: Category Scoring

The final rule for MACRA, published on November 4, 2016, established a unified scoring system for the four MIPS performance categories and determined that cost information would not be weighted into the composite performance score until 2018 (corresponding to payment adjustment in 2020).¹⁴ Table 4 lists the weight and scoring methodology for calculating MIPS composite performance scores in the first 2017 performance period. MACRA requires that performance standards be published for the measures and activities in each of the four performance categories.¹⁴ This new transparency of performance standards combined with a unified scoring system that converts collected measures and activities into points now allows eligible providers to know in advance what they need to do in order to achieve top performance.

For the quality category, which represents 60% of the weighted MIPS composite score in the 2017 performance period, clinicians may receive 3–10 points for each measure (N=6 for full performance) that is reported.¹⁵ The distribution of points will depend on the availability of a benchmark and whether or not the clinician meets volume and reporting criteria. When a benchmark is available and the provider (or provider group) meets the necessary volume and reporting criteria, 3–10 points will be assigned for each measure based on provider performance.¹⁵ However, if a benchmark is not available, then the provider will only receive 3 points for that measure.¹⁵ Clinicians who choose not to report a measure will receive 0 points for that measure.¹⁵ Providers may receive bonus points for submitting an additional high-priority measure or using certified electronic health record technology to submit measures to registries or CMS.¹⁵ The total number of quality points for each provider (or provider group) plus the number of bonus points will then be divided by the maximum number of points available.

The advancing care information category represents 25% of the weighted MIPS composite score for the 2017 performance period and is composed of three parts: the base score, the performance score, and the bonus score. The base score accounts for 50% of the advancing care information score and is determined based on performance in the 5 required advancing care information measures.¹⁵ The performance score, worth up to 90% of the advancing care information score, will be available to clinicians who report up to 9 advancing care information measures or up to 7 advancing care information transition measures.¹⁵ The choice between advancing care information measure and advancing care information transition measures depends on the providers electronic health record edition.² Finally the bonus score, worth up to 15% of the total advancing care information score, will be available to providers who receive bonus points for, 1) reporting any one of four public health and clinical data registry reporting measures, or 2) using certified electronic health record technology to report certain improvement activities.¹⁵ The final advancing care information score, worth 25% of the weighted composite MIPS score, will be a sum of the base score (50%) plus the performance score (up to 90%) plus the bonus score (up to 15%).¹⁵ Providers who earn 100% or more will receive the full 25% for the advancing care information category.¹⁵

For the improvement activities category, which represents 15% of the weighted MIPS composite score in the 2017 performance period, providers may receive a maximum of 40 total points.¹⁵ Each measure or “activity” is given a weight of medium or high, and the points assigned to each weight category depend on the provider’s practice size and organization.¹⁵ Clinicians in small, rural, or underserved practices will receive higher weights for participating in improvement activities, and clinicians in patient centered medical homes or other qualifying APMs will receive full credit.¹⁵ The total number of points for each provider will be divided by the maximum number of 40 points and the ratio will be multiplied by 100 to determine the improvement activities category score.¹⁵

Step 3: Composite Performance Score Calculation

Figure 3 illustrates an example of calculating a final MIPS composite score for the 2017 performance period, which does not incorporate performance in the cost/resource use

category. Performance feedback for cost measures previously collected for the value-based modifier will be given to providers for the 2017 performance period, but this data will not be factored into the composite MIPS performance score for 2017 and will not be used to adjust reimbursement in 2019.¹⁵ For the 2017 performance period, the total range of potential composite MIPS scores among all eligible providers will be 0 to 100 with a maximum of 60 points from the quality category, 25 points from advancing care information, and 15 points from improvement activities.¹⁵ Composite MIPS performance scores will be calculated for each eligible provider. Providers participating in MIPS as a group (e.g., with a single TIN) will receive one composite MIPS score.¹⁵

Steps 4–6: Composite Performance Score Comparison to Threshold and Payment Adjustment

After calculating composite MIPS performance scores for all eligible providers (or provider groups), scores will be compared to a performance threshold to determine payment adjustment and scaling. Eligible providers below the performance threshold will receive a scaled negative payment adjustment and providers above the performance threshold will receive a positive scaled payment adjustment. For the 2017 performance period, the range of potential adjustments will be –4% to +4% with adjustment application in January 2019.¹⁴ The final rule established a MIPS performance threshold of 3 points for the first transitional performance period in 2017, in order to allow clinicians who successfully report at least one quality measure to avoid negative adjustment in 2019.¹⁴ Clinicians who achieve a final score of 70 or higher will also be eligible to receive additional positive adjustments for exceptional performance.

Discussion

Plastic surgery is a unique field that often practices at the end of various different referral patterns. The quality and cost of care we deliver in the context of a disease episode is often directly affected by providers and health systems prior to our first encounter with the patient. Although the MIPS scoring will be applied in many cases to individual plastic surgeons or plastic surgery groups, many of the available measures included in the MIPS categories evaluate activities that are not under direct control of the provider. Similarly, many outcome measures, such as hospital readmission, blood glucose control, and surgical site infection, are the result of many different factors external to the practice of plastic surgery. In the coming years under MACRA, the requirements for qualifying advanced APMs will expand and care will likely become more consolidated into large interdisciplinary networks.¹⁷ To optimize performance in MIPS for the 2017 performance year and in the future, plastic surgeons will likely need to identify ways to increase their structural performance and coordination capacities with other referring specialties. For example, many plastic surgeons participating in MIPS will require certified electronic health records that are capable of submitting performance data to CMS and facilitate electronic cross-disciplinary referral and coordination of care. Plastic surgery will also need to actively invest in necessary health services research to: 1) establish clear surgical indications and evidence-based treatment algorithms, and 2) develop accurate and sensitive performance metrics that are most relevant to the population of patients we treat.

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Figure 2.
Steps to Determining MIPS Payment Adjustment for the 2017 Performance Period

Figure 3.
Calculating a Composite MIPS Score for the 2017 Performance Period

MIPS Performance Categories and Reporting Requirements for the 2017 Performance Period

Table 1

MIPS Category	General Reporting Requirements	Available Measures
Quality	<ul style="list-style-type: none"> Report up to 6 quality measures (including an outcome measure) OR a specialty measure set for a minimum of 90 days 	<ul style="list-style-type: none"> 271 individual measures
	<ul style="list-style-type: none"> Groups using the web interface: report 15 quality measures for a full year 	<ul style="list-style-type: none"> 11 measures in plastic surgery measure set (Table 2)
	<ul style="list-style-type: none"> Groups in APMs qualifying for special scoring under MIPS will report measure through the APM 	
Advancing Care Information	<ul style="list-style-type: none"> Fulfill 5 required measure for a minimum of 90 days <ul style="list-style-type: none"> Security risk analysis E-prescribing Provide patient access Send summary of care Request/accept summary of care 	<ul style="list-style-type: none"> Two available measure set options. Choice depends on the providers' electronic health record edition. <ul style="list-style-type: none"> Option 1: Advancing care information objectives and measures (15 measures) Option 2: 2017 Advancing Care Information Transition Objectives and Measures (11 measures)
	<ul style="list-style-type: none"> May choose to submit up to 9 measures for additional credit 	
	<ul style="list-style-type: none"> May receive bonus credit for reporting public health and clinical data registry measures or using certified electronic health records to complete certain activities in the improvement activities category 	
Improvement Activities	<ul style="list-style-type: none"> Attest that you completed up to 4 improvement activities for a minimum of 90 days 	<ul style="list-style-type: none"> 92 available measures in 8 subcategories <ul style="list-style-type: none"> Achieving health equity (4) Behavioral and mental health (8) Beneficiary engagement (23) Care coordination (14) Emergency response and preparedness (2) Expanded practice access (4) Patient safety and practice assessment (21) Population management (16)
	<ul style="list-style-type: none"> Groups with 15 or fewer participants or if you are in a rural or health professional shortage area: attest that you completed up to 2 activities for a minimum of 90 days 	
	<ul style="list-style-type: none"> Participants in certified patient-centered medical homes and certain qualifying APMs will automatically earn some points and may receive full credit 	
Cost/Resource Use	<ul style="list-style-type: none"> No data submission required. Calculated from claims. 	

Table 2

Plastic Surgery Quality Measure Set

Measure	Type	Description
Care plan	Process	Percentage of patients with age 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
Closing the Referral Loop: Receipt of Specialist Report	Process	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred
Documentation of Current Medications in the Medical Record	Process	Percentage of visits for patients with age 18 years and older for which the eligible provider attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include all known prescriptions, over-the-counters, herbals, and vitamins
Patient-Centered Surgical Risk Assessment and Communication	Process	Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon
Perioperative Care: Selection of Prophylactic Antibiotic – 1 st or 2 nd Generation Cephalosporin	Process	Percentage of surgical patients with age 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	Process	Percentage of surgical patients with age 18 years and older undergoing procedures for which venous thromboembolism (VTE) prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Process	Percentage of patients with age 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m ²
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Process	Percentage of patients with age 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated
Preventive Care and Screening: Tobacco Use, Screening and Cessation Intervention	Process	Percentage of patients with age 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
Surgical Site Infection (SSI)	Outcome	Percentage of patients with age 18 years and older who had a surgical site infection (SSI)
Tobacco Use and Help with Quitting Among Adolescents	Process	The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user

Table 3

Data Submission Options for Individuals vs. Groups Participating in MIPS

MIPS Category	Individual Reporting Options	Group Reporting Options
Quality	• Qualified clinical data registry (QCDR)	• Qualified clinical data registry (QCDR)
	• Qualified registry	• Qualified registry
	• Electronic health record	• Electronic health record
	• Claims	• Claims
		• CMS web interface (groups of 25 or more)
Advancing Care Information	• Attestation	• Attestation
	• Qualified clinical data registry (QCDR)	• Qualified clinical data registry (QCDR)
	• Qualified registry	• Qualified registry
	• Electronic health record	• Electronic health record
		• CMS web interface (groups of 25 or more)
Improvement Activities	• Attestation	• Attestation
	• Qualified clinical data registry (QCDR)	• Qualified clinical data registry (QCDR)
	• Qualified registry	• Qualified registry
	• Electronic health record	• Electronic health record
Cost/Resource Use	• No required data submission, will be calculated from claims	• No required data submission, will be calculated from claims

Calculating the Composite MIPS Performance Score for the 2017 Performance Period

Table 4

MIPS Category	Scoring Weight	Scoring Methodology
Quality	60%	<ul style="list-style-type: none"> Clinicians receive 3–10 points on each quality measure based on performance against standardized benchmarks (if available) – Clinicians who participate longer will have easier time meeting case volume criteria needed to receive more than 3 points – Volume criteria ≥ 20 cases for most measures; ≥ 200 cases for readmissions – Data completeness is required (at least 50% of possible data is submitted) – If measure cannot be reliably scored against a benchmark then clinician will receive 3 points for reporting data
		<ul style="list-style-type: none"> Failure to submit performance data for a measure = 0 points
		<ul style="list-style-type: none"> Clinicians may receive bonus points for either of the following – Submitting an additional high priority measure – Using certified electronic health record technology to submit measures to registries or CMS
		<ul style="list-style-type: none"> Base score (50%): determined by performance in the 5 required measures Performance score (up to 90%): determined by performance in additional measures Bonus score (up to 15%): providers may receive additional points for
		<ul style="list-style-type: none"> – Reporting any of the following public health and clinical data registry reporting measures <ul style="list-style-type: none"> ◆ Syndrome surveillance reporting ◆ Electronic case reporting ◆ Public health registry reporting ◆ Clinical data registry reporting – Using certified electronic health technology to report certain improvement activities
Advancing Care Information	25%	<ul style="list-style-type: none"> Final score (maximum 100%) = base score (50%) + performance score (up to 90%) + bonus score (up to 15%)
		<ul style="list-style-type: none"> Maximum total points for this category = 40
		<ul style="list-style-type: none"> Each completed measure or “activity” is assigned points based on whether the activity is determined to have a medium or high weight
Improvement Activities	15%	<ul style="list-style-type: none"> – For the majority of clinicians: medium weight = 10 points, high weight = 20 points – For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups: medium weight = 20 points, high weight = 40 points
		<ul style="list-style-type: none"> Clinicians in patient-centered medical homes or similar qualifying APMs will receive full credit
Cost/Resource Use	0%	<ul style="list-style-type: none"> Cost measure collected for the value-based modifier include:

MIPS Category	Scoring Weight	Scoring Methodology
		– Medicare spending per beneficiary
	*Will begin in 2018	– Total per-capita cost for all attributed beneficiaries
		• CMS will still provide feedback on how providers performed in this category in 2017, but it will not affect 2019 payments