Methodology: 2018 QPP Experience Report Public Use File

1. **Background** – The 2018 Quality Payment Program (QPP) Experience Report Public Use File (PUF) includes detailed data at the TIN/NPI level regarding clinician eligibility, performance category scoring, final score, and payment adjustments. Since the PUF provides data at the TIN/NPI level, we have suppressed TIN/NPIs with fewer than 11 beneficiaries in 2018 per CMS rules. For that reason, and because these data are more recent, the numbers in the PUF will not match those in the QPP Experience Report.
2. **Methodology and Key Data Sources** – The primary data source used to compile this dataset is the CMS's systems of records for Merit-based Incentive Payment System (MIPS). MIPS contains data sourced from Medicare Part B Claims and Provider Enrollment, Chain, and Ownership System (PECOS) in addition to measure and activity data collected and submitted for clinicians and practices. The "Definition" field in the "Data Dictionary", provides further information on the data fields.

    2.1. Eligibility Determination – This PUF only contains data for clinicians determined to be eligible for MIPS payment adjustment. For MIPS Eligibility, CMS reviews past and current Medicare Part B Claims and Provider Enrollment, Chain, and Ownership System (PECOS) data for clinicians and practices twice for each Performance Year (each review is called a determination segment). Data from the two segments are then reconciled and released as the final eligibility determination.

        2.1.1. Provider Key – Random unique key assigned to each row

        2.1.2. Clinician Specialty – The specialty description is an identifier corresponding to the type of service that the clinician submitted most of their Physician Fee Schedule Part B claims.

        2.1.3. Beneficiaries – The number of Medicare patients who receive services, aggregated at the submission level. For example, if the Group submission was used for the final score, the Group's beneficiary count is displayed for each Clinician who achieved a Final Score through that Group.

        2.1.4. Allowed Charges – The allowed Physician Fee Schedule Part B claims charges with a service date during the performance period, aggregated at the submission level. For example, if the Group submission was used for the final score, the Group's allowed charges are displayed for each Clinician who achieved a Final Score through that Group.

2.1.5. Practice State or US territory – The Practice State or US territory code location of the clinician's billing practice.

2.1.6. Practice Size – Count of clinicians associated with TIN based on the last determination period.

2.2. Reporting Factors – There are certain factors (including Special Statuses, QPP Exceptions and Facility-based Determinations) that can affect the clinician reporting requirements for the different performance categories. These factors can result in fewer or no reporting requirements for a specific performance category.

2.2.1. Rural clinician – Indicates if a clinician is practicing in a rural area.

2.2.2. HPSA Clinician – Indicates if a clinician is practicing in a Health Professional Shortage Area (HPSA).

2.2.3. Ambulatory Surgical Center – Indicates if the clinician furnishes 75% or more of their covered professional services in sites of service identified by Place of Service (POS) code 24.

2.2.4. Hospital Based Clinician – Indicates if the clinician furnishes 75% or more of their covered professional services in a hospital setting.

2.2.5. Non Patient Facing – Indicates if the clinician has 100 or fewer Medicare Part B patient-facing encounters (including telehealth services).

2.2.6. Extreme Hardship – The clinician practice was located in a Center for Medicare & Medicaid Services (CMS)-designated region that has been affected by an extreme and uncontrollable event (such as FEMA-designated major disaster) during the 2018 MIPS performance period.

2.2.7. Extreme Hardship Quality – Indicates if the clinician was approved for an exemption of the Quality performance category due to extreme and uncontrollable circumstances.

2.2.8. Extreme Hardship PI – Indicates if the clinician was approved for an exemption from the Promoting Interoperability performance category due to extreme and uncontrollable circumstances.

2.2.9. PI Hardship – Indicates if the clinician was approved for an exemption from the Promoting Interoperability performance category due to small practice, decertified EHR technology, insufficient Internet connectivity, or lack of control over the availability of CEHRT

2.2.10. PI Reweighting – Indicates if the clinician qualified for an automatic exemption from the Promoting Interoperability performance category due to special status or clinician specialty.

2.2.11. Extreme Hardship IA – Indicates if the clinician was approved for an exemption from Improvement Activities performance category due to extreme and uncontrollable circumstances.

2.2.12. IA Study – TRUE if Improvement Activities Study data is present otherwise, FALSE.

2.2.13. Extreme Hardship Cost – Indicates if the clinician was approved for an exemption the Cost performance category due to extreme and uncontrollable circumstances.

2.3. Performance Scoring – This PUF contains the performance category scores, measurements, and activities that make up the final score. Performance is measured through the data clinicians report in four areas - Quality, Improvement Activities, Promoting Interoperability (formerly Advancing Care Information), and Cost.

2.3.1. Participated – Indicates if the clinician reported data or received a Final Score greater than zero

2.3.2. Participation Type – Indicates the reporting method from which the clinician received its final score. The participation type is selected by the submitter.

2.3.3. Quality Category Score – This is the unweighted score received by the participant for the Quality score that is used for the overall score.

2.3.4. Quality Bonus – The total Quality bonus points received by the clinician for the Quality category

2.3.5. Quality Measure ID # – Measurement ID of one of the Quality measures that contributed to the final score

2.3.6. Quality Measure Score # – Measurement score achieved of the corresponding Quality measurement ID that contributed to the final score

2.3.7. Promoting Interoperability (PI) Category score – This is the unweighted score received by the participant for the PI category, the score that is used for the final score. MIPS APM participants use their APM Entity roll-up score.

2.3.8. PI Bonus – The total PI bonus points received by the clinician for the PI category

2.3.9. PI Measure ID # – Measurement ID of one of the PI measures that contributed to the final score

2.3.10. PI Measure Score # – Measurement score achieved of the corresponding PI measurement ID that contributed to the final score

2.3.11. IA Score – The score received for the IA category based on all the IA measures picked and IA bonuses received for the category that contributed to the final score.

2.3.12. IA Measure ID # – Activity ID of one of the IA measurements that contributed to the final score

2.3.13. IA Measure Score # – Measurement score achieved of the corresponding IA measurement ID that contributed to the final score

2.3.14. Cost Score – The unweighted score received for the Cost category based on all the cost measures reported and used for final scoring.

2.3.15. Cost Measure ID # – Measurement score achieved of the corresponding Cost measurement ID that contributed to the final score

2.3.16. Cost Measure Score # – Measurement ID of one of the Cost measures that contributed to the final score

2.3.17. Final Score – The overall score received by the eligible clinician for the performance year.

2.3.18. Payment Adjustment – The payment adjustment received by comparing the overall score obtained by the eligible clinician to the performance thresholds.