MIPS Quality Performance Category Overview for Year 3 (2019) of the Quality Payment Program
February 5, 2019

Hello, everyone. Thank you for joining today's MIPS Quality Performance Category for Year 3 (2019) of the Quality Payment Program webinar. The purpose of this webinar is to provide information about the Merit-based Incentive Payment System (MIPS) Quality performance category for Year 3 (2019) of the Quality Payment Program. The presentation will be followed by a Q&A session where attendees will have the opportunity to ask questions. Now I will turn it over to Adam Richards, Health Insurance Specialist in the Center for Clinical Standards and Quality at CMS. Please go ahead.

All right, well, thank you, and hello, everyone. Thank you all for joining us today to learn about and discuss various elements of the Quality performance category under the Merit-based Incentive Payment System for the 2019 performance year. Many of you on the call today may be aware that the reporting timeframe for the Quality performance category is 12 months, which is similar to the 2018 performance year, so our goal was to try to host this webinar as early as possible to make sure that each of you understand and are comfortable with the requirements within this category. So, we have a lot of very rich information to cover today, and we anticipate having some time at the end to address your questions. We also have a very great panel assembled, and I'm thrilled to be joined by Sophia Sugumar, Doctors Dan Green and David Nilasena, all of whom are leading experts in our Quality performance category, MIPS scoring, and some of our other focus areas. So, I do want to thank each of them for being here with us today. Two housekeeping items before we get started. We are not going to deep dive into the general MIPS program requirements today. We'll gloss over a few of those key elements early on with Dr. Dan Green, but our focus is strictly on the Quality performance category. I do highly recommend that you review our slide deck and recording from our MIPS 101 webinar that we hosted about two weeks ago. I think there's a lot of valuable content included within that will help get you started. You can just go to qpp.cms.gov and go to our webinar library for that information. Additionally, anyone who is on the line today and has joined us before knows that we encourage you all to sign up for the Quality Payment Program listserv. It's a very simple process. Just visit qpp.cms.gov, scroll to the bottom of the page, and enter your e-mail. The minute or two that it'll take you will keep you up to date on all things QPP. It's a really fantastic resource. So, with that said, I'm going to pass it over to Dr. Green to kick off our discussion today about the Quality performance category.

Great. Thanks, Adam. Welcome, everybody. So glad you all could join us today. Hopefully, you're calling in from a place that you're able to enjoy some of this early spring that the groundhog promised us over the weekend. If not, sorry. We're going to start on slide number three, and basically, this slide is discussing how the Quality Payment Program came into being. And it was basically authorized through the MACRA legislation, the Medicare Access and CHIP Reauthorization Act, which was passed in 2015. It did require CMS to develop and implement an incentive program, which we've done. We call it the Quality Payment Program, and there are two ways that folks can participate in the Quality Payment Program. They can participate under the Merit-based Incentive Payment System, or MIPS, or they can participate through an Advanced Alternative Payment Model, or Advanced APM, as we call them. So, if you are a MIPS eligible clinician and you're not reporting under an APM, it's important for you to participate in the program or you could be subject to a

negative payment adjustment. Your participation, however, also could warrant you a payment adjustment in the positive direction. So, folks can earn incentive payments by participating in MIPS. If you decide to take part in an Advanced APM, you can also earn a Medicare incentive payment for sufficiently participating in the innovative payment model that you choose.

So, we're going to move on to slide five now. No, four's a text slide. My right-hand person is trying to keep me on target, but... Okay, so we're on slide five now, and you can see that, to give a quick overview of the MIPS program, basically, it's a combination, albeit changed to a degree, but it's a combination of some of the legacy systems. Many of you may be familiar with or remember the Physician Quality Reporting System. I know you were so sorry to see it go and be retired, but, well, all good things must come to an end. Also, the Value-based Payment Modifier, or VM program. And then, of course, the Medicare EHR Incentive Program for eligible clinicians. So, these three legacy programs, again, were modified but combined into the MIPS program, and then, as we'll see in the next slide -- so if we could move on to slide six, please -- there is another category that was added.

So, you can see the four categories, MIPS performance categories. They're quality, cost, improvement activities, which is the new category that wasn't in one of the legacy programs, and then we call the EHR program now promoting interoperability. If you look beneath these little symbols, you can see how much -- what percent of the MIPS final performance score -- each of these components comprises. So, you can see, again, that quality's 45% while cost and improvement activities account for 15% each, and the promoting interoperability is 25%. So, the points that are earned in each of these categories are added together, and they do give a final MIPS score. And then the MIPS score that you receive or that you've earned is compared to other participants in the program, and based on where you fall there, you either would have a neutral or no payment adjustment, or you could have a positive or negative payment adjustment to your future Medicare billings.

Looking at slide seven, please. Excuse me. This slide basically just talks about the 2019 MIPS eligible clinicians. So, you can see physicians and physicians assistants as well as nurse practitioners, clinical nurse specialists, and CNRAs have all been previously in MIPS, but you can see now in 2019 occupational therapists, physical therapists, psychologists, audiologists, speech language pathologists, now dieticians, and/or groups comprising these clinicians are also MIPS eligible clinician types.

Next slide, please. So, while on slide seven we defined the types of clinicians that are in MIPS, there are some other tests that are used to determine whether someone has to participate in MIPS. And basically what we've sought to do is try to eliminate folks that really care for very few Medicare bennies. So, we look at basically whether or not an individual has a certain number of charges and Medicare bennies as well as Medicare beneficiary services provided in a year to determine whether or not they actually have to participate, excuse me, in MIPS or whether they can elect to participate in MIPS or whether they're precluded altogether. So, you can see here on the slide that the first thing is an eligible clinician has to bill more than $90,000 of allowed charges under the Medicare Physician Fee Schedule in a given year. They have to care for and provide services for more than 200 Medicare bennies, as well as provide more than 200 covered professional services under the Physician Fee Schedule. So, if they meet all three of those criteria, they are deemed a MIPS eligible clinician and they do need to participate, and if they choose not to participate, they will get

a negative payment adjustment, so that basically would be a penalty in 2021 based on the charges that come in. So, again, if you exceed all three, you definitely should participate. If you don't exceed all three criteria, you're excluded from MIPS. However, there is an opt-in policy, which we can talk about at another time.

Next slide, please -- number nine. So, just want to go over the general timeline. So, right now, as you know, this program is -- we're talking about the 2019 performance year. So that started January 1st,and it will close December 31st. So, this would be for services provided to patients in these 12 months. So, you would basically see the patient, provide the care you'd provide, and then depending on whether there's a quality measure associated with that care, that information could be uploaded if you're using a registry, perhaps through a web portal, it's an EHR. It could potentially be automatically uploaded at your direction. Or if you're submitting a copy of claims for a claim-based measure, you would append a quality data code to your claim. In any case, the data that you provide to, if you're using a third-party intermediary such as a registry, Qualified Clinical Data Registry, or electronic EHR vendor to submit your data, or your own data if you're sending it in, that data is -- unless it's claims, which of course would be real-time, but if you're using a third-party intermediary, that data would be submitted between January 1st of 2020 and March 31st of 2020. We do encourage folks to submit early and often. If there are any bugaboos in your system that, for whatever reason, we're not receiving the data, obviously the earlier you discover that, the earlier you can reach out to us for help so that, in fact, all the data is included, which again, would count as your participation and hopefully help you avoid any kind of negative payment adjustment. CMS does provide feedback after the data is submitted. So, you will receive your feedback before the start of the payment year. The payment adjustment, as I alluded to earlier, starts on January 1, 2021, so if you are due, let's say, for a 1% payment incentive, all of your Medicare covered Part B services would receive a 1% adjustment. So, in other words, if your allowable charge was $100, so that's what Medicare was going to send you, we would send you $101 for that particular service.

Okay, if we could move on now to slide number 11, that would be great, please. Going to spend just a minute talking about the Quality section, and particularly, what quality measures are. So, quality measures are tools or metrics that help us and the clinicians see how well he or she is performing on a particular either activity, or in some cases, what their outcomes are. So, an example would include -- there's different measures which we'll talk about in the next slide, but for example, there's a metric on the flu vaccination. So, you know, you could look and see, if you're reporting that measure, what percentage of your patients who should be getting a flu shot are getting a flu shot. Most clinicians when they go to work in the morning think that they're practicing great medicine, and of course, the majority are, but sometimes we're surprised by the information that we receive when we actually go to measure it, and we think, "Hey, I'm telling all my patients to get flu shots, but wow, only 50% are doing it. I need to spend more time with them talking about that," for example. Similarly, surgeons, for example, and other procedurals may want to look at the outcomes of the surgeries or activities that they perform on their patients, or even primary care docs. "Hey," you know, "how good a job am I doing at managing my patient's sugar level if they're diabetic?" Again, the surgery, "Did I have complications?" These are examples of different types of measures, and of course, patient experience of care is another. So how does your patient perceive the care that he or she received from you? Did they feel that they got better? Are

they able to walk now after their knee replacement? Things like that. So, those are just some examples, and we'll see on the next slide, slide 12, where we actually more specifically define the different types of measures.

So, you can see process measures are kind of like that flu measure that I described. You know, it's a "Did you do a particular activity? Did you measure hemoglobin A1c? Did you give the flu shot? Did you give the pneumococcal vaccination? Did you get a mammogram?" These are examples of process measures. So, outcome measures, again, look to see what the outcome was. There's a measure that our ophthalmologists have sent in looking at visual acuity within 90 days after cataract surgery. So, you know, we did the cataract surgery. "Does the patient have good vision now? Are they able to see better, if you will?" There's measures that relate to complication rates. Again, these are outcome measures. Structural measures give consumers a sense of a healthcare provider's capacity or their systems. In other words, do they have an emergency plan in place in their office if a patient has an allergic reaction to a particular medication or an anaphylactic reaction? So that, for example, could be an example of a structural measure. Then, of course, there's patient engagement and experience measures. So, we talked briefly about this on the previous slide in terms of looking at how patients perceived the care that they received. You know, "Was their doctor attentive? Did they feel they got good care?" Or it could also be, you know, "Are they doing better after having this interaction with the clinician?" So, if it were surgery, you know, "Hey, are you able to, as we talked about, walk better, for example?" Then there's some intermediate outcomes. So, these look at short-term results that may lead to an ultimate outcome of better health. An example of this is checking a patient's hemoglobin A1c. Now, the actual checking of the value, of course, doesn't do anything, but if we have a patient who is considered reasonably well controlled with their diabetes, that's a proxy for the future in terms of having fewer complications from their disease. So, that would be considered an intermediate outcome.

Next slide, please -- slide 13. Some additional types of measures include efficiency measures. So, we think of these as appropriate use measures. So, you know, over-ordering, over-prescribing would be examples of efficiency measures. So, you know, "Did somebody give a patient an antibiotic for a virus, or for, you know, outer ear infection?" are some examples of efficiency measures. Or patient comes in with back pain but without neurologic symptoms and they are sent straight away for an MRI. You know, these would be potentially over-use measures. Pardon me. So, we talked earlier about patient-reported measures, and, you know, I think I mentioned there are two types. There's the patient-reported experience, so, you know, "Was my doctor attentive? Did he or she listen to me and address my concerns? Did they go over the instructions? Did I receive informed consent?" All those kinds of things. And then there's patient-reported outcomes, which I think I alluded to earlier with things like, you know, "Am I able to walk better after my knee or joint replacement?" Some of the measures that we consider as high priority in the agency, well, we certainly put a premium on outcome measures, 'cause those obviously have direct bearing on how the patient is doing. Patient experience are important measures for us. Obviously, patient safety is paramount and important to the patient, important to us, important to the clinician. Efficiency measures. So, we want to make sure that, you know -- healthcare is expensive, but we want to make sure that those dollars are being used appropriately as indicated, and again, that speaks to appropriate use, which is the next one. And then care coordination. Anyone that's practiced medicine can attest to the importance of communication between clinicians that are caring for particular individuals. So, we do put

a premium on care coordination. And then unfortunately, our country is experiencing a healthcare crisis with the opioid epidemic, and as a result, we have highlighted the opioid-related quality measures as high-priority measures.

Next slide, please. So, some of our goals with regard to measures in the program -- we are trying to incrementally remove process measures, and we consider things like -- well, one thing we consider is, by removing these measures, we now make it such that a clinician doesn't have enough measures to report. Does the measure address a priority or high-priority set or topic that I just mentioned? Does the measure lead to positive outcomes in patients? So again, an important thing to consider. We also looked at whether or not the measure itself is what we call topped out. So, you know, are all the clinicians that are reporting the measure reporting or performing it, let's say, 95% of the time? We recognize that 100% is not a realistic goal for most measures, so it may be that we've driven the care paradigm, and for that particular measure as far as we can drive it, so maybe it's time to retire the measure and have a clinician focus on something else. We talked about the high priority, and then we talked about high- or topped-out range. So, I think I'm going to stop there and turn it over to my esteemed colleague, Sophia Sugumar.

Thanks, Dr. Green. Can we move to slide 16, please?

Excuse me.

Thank you. So, with regards to the Quality performance category and reporting requirements for 2019, as Dr. Green mentioned earlier, the Quality performance category will weigh in as 45% of your MIPS final score. Similar to the 2018 performance period, we do require a 12-month reporting period, and for the 2019 performance period, we have an inventory of 257 MIPS quality measures that have been finalized through rule making that are available for reporting. In terms of the actual requirements themselves, they have not changed since 2017, so that is we have to require that you report six individual measures, and one of them should be an outcome measure or another high-priority measure if an outcome measure is not available. And Dr. Green did go over the high-priority definition before, but just as a recap, that covers outcome, patient experience, patient safety, efficiency, appropriate use, care coordination, and opioid-related measures. If less than six measures apply, you should report on each applicable measure. The scoring implications of that will be discussed later on in this presentation, so we will hold off on that. Other options that are available for reporting is that clinicians can report on a specialty specific set of measures, and those specialty sets, you are required to report at least six measures, or at least what was in the set. So, some of the specialty sets do have less than six measures, and that is all you're required to report. Alternative methods of reporting also include the Web Interface. That is available for groups. We will discuss that a little bit later. You would have to report all 10 quality measures within the Web Interface in order to satisfy those reporting requirements. In addition to the MIPS quality measures, there's also QCDR measures, which are available through our Qualified Clinical Data Registries, and those are quality measures that are outside the MIPS quality measure inventory that are developed based off of the needs that we've heard through various specialties. So, those are also available through those QCDRs, as well.

Can we move to slide 17, please? Thank you. For 2019, there are bonus points available. For example, two points for any additional outcome or patient experience measure after the first one that is required. There is a one point additional bonus for high-priority measures, again, after the first required measure is submitted. There's also one point for each measure submitted using end-to-end reporting when that data has to be derived from a certified EHR source. There is also a small practice bonus available of six points. We do look for, also, within the reporting requirements through data completeness. What does that mean? We check to see that you and your group have submitted data on a minimum percentage of your patients that meet a quality measures denominator criteria. In 2019, the thresholds are 60% for data submitted on QCDR measures, MIPS CQMs, what was previously known as registry measures, and this is on all payer data. For measures that are specified as Medicare Part B claims, the threshold is still the same at 60%, but we are limited to Part B data there. Measures that do not meet data completeness will only earn one point. The only caveat to that is that small practices will receive three points for any measure that does not meet data completeness.

Can we move to slide 18, please? Getting into the details of the Web Interface submission method, the Web Interface is available for groups and virtual groups that have at least 25 or more clinicians participating in MIPS and MSSP ACOs reporting on behalf of the MIPS eligible clinicians. They must be registered and choose to submit data through the CMS Web Interface, where they are required to report on all 10 measures for a full year from January 1 to December 31, 2019. And below, we provide a table of the 10 measures for your reference.

Slide 19, please. All right, we're going to discuss a little bit more detail about the data collection methods that are available for quality.

Slide 20. With regards to quality reporting for the individual level, we do have measures specified at the eCQM collection type, the MIPS CQM collection type, as I mentioned, that was previously known as registry measures. QCDR measures, which are available through QCDRs, and the Medicare Part B claims measures, which have been limited to small practices only, and that is a policy that was finalized within the 2019 rule. For the groups, we have those same collection types available, eCQMs, MIPS CQMs, QCDR measures, and the Medicare Part B claim measures, also limited, again, to small practices. But in addition to that, we also have a CMS Web Interface, the CAHPS for MIPS measures also available to groups, as well as the administrative claims measure.

Slide 21, please. Thank you. For the collection type of QCDR, we have QCDR measures, and this is available for individuals, groups, and virtual groups. So, CMS approved QCDRs will collect the medical data or clinical data to track patients and disease. Each QCDR has typically given customized instructions about how they collect the data and will help provide that guidance to the clinicians that choose to report through their QCDR. For MIPS, eligible clinicians who choose this option have to participate within the QCDR that we've approved. So, every year, we do post a list of approved QCDRs through what we call a qualified posting, and that's available in the QPP Resource Library. And there, you'll have a list of, I believe in alphabetical order, of all the QCDRs and the measures they support for the year and the fees that they charge, so that that is readily available to our clinicians that are interested in using that submission method. Another way of reporting is through MIPS CQMs, and that is also available for individuals, groups, and virtual groups. MIPS CQMs are typically collected by

registries and QCDRs and are submitted via the direct or log-in and upload submission methods on behalf of the eligible clinicians. Eligible clinicians who choose this collection type will have to participate in the registry or a QCDR that we have approved. And again, same as the QCDRs, we do have a qualified posting of the approved Qualified Registries available on the QPP Resource Library.

Slide 22, please. All right. With regards to the eCQMs, or what's known as Electronic Clinical Quality Measures, those are also available to all three submitter types of individuals, groups, and virtual groups. Clinicians will have to collect their data through their certified EHR technology. Groups and virtual groups will have to collect the data used. If they use multiple EHRs, we'll have to collect the data and aggregate that data before it's submitted. It's important to note that if you're submitting eCQMs, you'll need to use the 2015 edition of CEHRT to collect the eCQM data. Your EHR technology will need to be certified to the 2015 edition by the last day of the performance period.

Can we move to slide 23, please? Thank you. The Medicare Part B claims measures is the next collection type, and it's also available to individuals, groups, and virtual groups with the caveat there that the collection type is limited to the MIPS eligible clinicians and small practices. So, clinicians and small practices can take measures and report through their routine billing processes. They will need to add their earned billing codes to claim files for denominator eligible patient encounters to show that the required quality action occurred or that the denominator exclusion was met. For the 2019 performance period, Medicare Part B claims must be submitted and processed no later than 60 days following the close of the performance period to be analyzed for the Quality performance category.

Slide 24, please. All right, and the administrative claims measure is also available, limited to groups and virtual groups. There's no data submission required for the administrative claims measure. In MIPS for quality purposes, we only have one measure -- it's the All-Cause Hospital Readmission measure. And groups or virtual groups of 16 or more clinicians are automatically subjected to this measure if they meet the case minimum of 200 patients. If the group or virtual group falls below that case minimum, the measure won't be calculated and clinicians will only be scored on their reported measures.

Slide 25, please. The CMS Web Interface measures are also limited to groups and virtual groups. How it works, and there is a secure internet-based application that pre-registered groups and virtual groups of 25 or more clinicians can use, a sample of the beneficiaries are identified for reporting, and we partially pre-populate the CMS Web Interface with claims data from groups, Medicare Part A and Part B bennies who've been assigned to the group. Then the group adds the rest of the clinical data for the pre-populated Medicare patients. The CAHPS for MIPS Survey is also limited to groups and virtual groups. Groups that choose to report their patient experience data via the CAHPS for MIPS Survey must pick another collection type and submit a submission type to collect and submit the rest of their quality measures, so this only counts for one measure. They'd have to submit their five other measures through another submission method. And they must meet the minimum sample size to administer the CAHPS for MIPS Survey. New for 2019, a group that wishes to voluntarily elect to participate in the CAHPS for MIPS Survey measure must use a survey vendor that is approved by CMS for the applicable performance period to transmit the survey data to us. And just as a note, groups and virtual groups interested in reporting through the CMS

Web Interface or administrating the CAHPS for MIPS Survey need to register at the qpp.cms.gov website between April 1 and July 1 of 2019. And with that, I believe that's my last slide. I will turn it over to Dr. David Nilasena to go over the scoring components.

Oh, sorry, I missed a slide. New for 2019, we have finalized a policy where we will aggregate quality measure submissions across multiple collection types, so if you choose to submit using both your EHR and a QCDR, we will aggregate those submissions and calculate your score that way. If the same measure is collected through multiple selection types, then they will be individually scored, but only the highest scoring measure will count. The CMS Web Interface measures cannot be scored with other collection types, and so we just want to caveat that, and if so -- sorry. CMS Web Interface measures cannot be scored with other collection types other than the CMS-approved survey vendor measure for CAHPS for MIPS and/or the admin claims measure. And that is my last slide, so I will now turn it over to Dr. David Nilasena for scoring.

All right, thanks, Sophia, and you caught me off guard there with the early slide, but now I'm ready. So, you've heard about what the quality measures are, kind of what kind of quality measures we have, and then how you get the data to CMS for the MIPS program. So, I'm going to talk about how we will score those measures that you've submitted for your contribution towards your final MIPS score.

Next slide, please. All right, so for each measure that either you submit to us, or in one case, the administrative claims measure that we calculate for you, you can get between one and 10 measure achievement points. So, 10 is the maximum you can get per measure. Now, each measure falls into one of three categories for the purposes of scoring. So, the first category is something we called being able to be scored against the benchmark. So, these are measures that meet our data completeness criteria of 60%, that they have an existing benchmark, and that they meet the case minimum, which is more than 20 cases or all measures except the all cost readmission measure. For measures that meet all three of those criteria, we are able to score them based on performance, and they can get between three and 10 points based on performance compared to established benchmarks. The second category is those measures that meet data completeness, but either lack a benchmark or do not meet the case minimum of 20 cases. In this case, we can't score them against the benchmark, and so those measures will get a flat three points towards the quality category. Then finally, the third category is those that do not meet our data completeness criteria. These measures will normally just get one point. We have an exception to that, which you're in a small practice, you will get three points for those measures. But basically, we're not able to score them and there's insufficient data, so you really get a minimum number of points for those measures.

Next slide. Now, I think Dan mentioned topped-out measures is one of our things we look for in sort of identifying measures for the quality category. We have policies that restrict the number of points that you can get for those measures that are determined to be topped out. Now, in 2018, we only had six measures that fell into this category, and they were each capped at seven points -- the maximum that you could get for those six measures. For 2019, which is our current performance period, we've fully implemented our topped-out policy, and so for all those measures that have been topped out for more than one year in a row, they will be limited in the number of points that they can get, and that will be capped at seven points rather than 10.

So, this slide shows some examples of those measures, but we actually have many more measures that have been identified as topped out, and those measures are listed in a resource on our QPP website for the quality benchmarks for 2019. There's a column that indicates whether the measures are topped out, and also whether they are subject to the seven point cap. Another new thing we have in 2019 is something called extremely topped-out measures. Now, these measures are measures that have an average mean performance that is basically greater than 98%. These measures are sort of an exception to our four-year timeline for retiring measures, and so extremely topped-out measures can be subject to removal at the next available rule making cycle. Now, of note, QCDR measures, we do not apply these rules to them since they have sort of their own criteria for being evaluated, for being topped out as part of the nomination process.

Next slide, please. All right, so I talked about scoring against benchmarks. How do we establish benchmarks for the Quality category? So, when you submit measures for MIPS, each one is assessed against a benchmark to determine the points that we just talked about. The way we establish this is we look prior to the reporting period, two-year look-back period, so for 2019, we look at 2017, and we look at the data that was submitted for the quality measures during that period. From that data, we determine whether we have sufficient data to create a benchmark, and this looks at things like the data was submitted by MIPS eligible clinicians or groups, it met the case minimum criteria and data completeness, that there were at least 20 instances reported for the measure that had performance greater than zero. If all those criteria are met, then we are able to create a benchmark used for scoring. If we're not able to do it in the two-year look-back period known as the historical benchmarks, then we will attempt to create benchmarks using performance-period data. So, in this case, that would be using the 2019 data. So, following the 2019 data submission window, we would look to see if we had enough data for each measure that lacked a benchmark to now create a benchmark, and if so, we would use those benchmarks for scoring. Now, benchmarks are created separately for each of the data collection types, so for MIPS CQMs, for QCDR measures, for Medicare Part B claims measures, and for eCQMs, they will each have their own separate benchmark used for scoring.

Next slide. Now, for the CAHPS for MIPS Survey, in the first year of the program, we did have historic data that we could use for benchmarking. However, the content of that survey has changed, and so we are no longer able to create a historic benchmark for the CAHPS for MIPS Survey for 2019. What this means is that you won't know what the benchmarks are until we finish the data collection for 2019. It's likely that we will be able to construct benchmarks for CAHPS using performance-period data since we usually have pretty good participation in that survey. But you won't know what those benchmarks are until following the performance year of 2019. We anticipate these will be available in the spring of 2020. Now, the benchmarks for the CMS Web Interface, we make use of the same benchmarks that are used in the Medicare Shared Savings Program, and these are historical benchmarks only. There's no performance-period benchmarks for the Web Interface, and those benchmarks are posted through the Shared Savings Program website.

Next slide. All right, so now once we have the benchmarks, how do we use them to create your score for each measure that you submit? So, again, the benchmarks are collection type specific, so first we see what collection type you were using for the measure you submitted. Each quality measure is scored on a 10-point scale. I mentioned that earlier. You can get between three and 10 points for those that can be scored against the benchmark. The exception,

again, is if it's a topped-out measure, you're limited to seven points. If you don't meet data completeness or don't meet the case minimum, then again, we can't score you based on performance. We break down each benchmark into deciles of performance, so there's 10 deciles for each measure, and those that are translated into scores corresponding to three to 10 points. So, for example, the third decile would get three or so points, and then the top decile, the 10th decile, would get 10 points. So, the higher up you are in the decile scoring, the more points you get for the measure. There is a three point floor, so if you happen to be in the first or second decile, you would still get three points for the measure as long as we could reliably score it and it met data completeness. And then we compare your performance to the quality measure to these performance levels and these national benchmarks, and that's what determines the points you get for each measure, again, between three and 10 points.

Next slide. All right, so we talked about reliably scored against the benchmark, so I won't go into that again, but basically, for those that we can't score, you're limited to three points. And again, if you don't meet data completeness, generally, you can only get one point unless you're in a small practice, and in that case, you can still get three points. And this applies to measures across all collection types except for the CMS Web Interface and administrative claims measures. So, they have different rules in terms of data completeness and benchmarks.

Next slide. All right, so Sophia talked about the bonuses, I think, that you can get. So, one is an end-to-end electronic bonus. And so, this is if you submit data from your certified EHR technology and it makes it all the way to CMS without any manual manipulation, you can get one bonus point per measure that meets those requirements. It's available for measures reported either through the direct, the log in and upload, or the CMS Web Interface submission types, and these bonus points are capped at 10% of your Quality performance category denominator. There's also bonus points for additional outcome and high-priority measures beyond the first required measure. For additional measures that are either outcome or patient experience, you can get two points, and for other high-priority measures, you can get one point. And again, these are capped at 10% of your total Quality category denominator. I would point out this is a separate cap from the end-to-end bonuses, so you could actually get 10% for end-to-end electronic reporting and 10% for high-priority measures.

Next slide. In 2019, we moved the small practice bonus, which was at the final score level. We moved it into the Quality category, and so now if you're in a small practice and you submit quality data, you will automatically get six points added to the numerator of your Quality category score. So, small practices are those with 15 or fewer clinicians, and so as long as you submit some data, you will get six points added to your score.

Next slide. Now, new for 2019, we will be giving points for improvement scoring. Actually, maybe did that in '18, too. And you can get up to 10 percentage points based on the rate of improvement in your Quality performance category from the prior year. Bonus points will not be used in the calculation for improvement scoring, so we'll just look at the actual score against benchmarks for each measure, and the bonus points will be incorporated into your overall category score, so not as part of the improvement scoring.

Next slide. All right, so the way the improvement scoring will work is first you have to participate fully in Quality performance category for the current year. This means you need to meet the full reporting requirements, which are generally six measures or a complete specialty measure set, and at least one outcome or high-priority measure. So, once you've met that reporting and you have complete data submitted, then you also need to have a Quality performance category score from the prior period, which in this case would be 2018. So, we need to have two periods to detect improvement. And then finally, you need to be submitting the data under the same identifier, meaning, like, a 10 NPI or a 10 for the two performance periods so that we can compare the results for the two periods.

Next slide. So, we determine improvement by comparing the Quality performance category achievement percent score from the previous period to the same thing for the current period. So, again, we're just looking at achievement points, not bonus points, and we look at the amount of improvement from the prior year to the current year, and then you're limited to a 10% cap on that improvement. So basically, we take the amount of improvement year over year, we multiply that by 10%, and then we cap it at a maximum of 10% of your score, and that will be your improvement percent score for the Quality category. So, as an example of this, let's say that your score last year for the Quality category was 30 points, and this year it was 60 points. That will be a 100% improvement. We'd multiply that by 10%, which would be 10% improvement, and then that's capped at 10%, so you're under the cap, so you would get the full 10% improvement points for the Quality category.

Next slide. And this just gives another example of improvement scoring, so if in 2018 your Quality performance category achievement percent score was 42% and in 2019, it was 55%, and again, these are excluding the bonus points, then your overall improvement would be 13% by subtracting the two from each other. You would divide that by the starting point, which was 42%, and then that would be capped at 10% to give you your improvement score.

All right, next slide, please. Okay, so this slide shows sort of the way the overall Quality performance category score is then determined. So, we take your total measure achievement points -- so this is by comparing each measure to the benchmark. We add in the bonus points, which could be either end-to-end electronic or high-priority bonus points, and we divide that by the total available measure achievement points. And then to that, we add your improvement percent score, and that will be your overall Quality category percent score. Now, I do want to take just a minute here, and I know we're running a little short on time, but we get a lot of questions about the total available measure achievement points, which is the denominator for the Quality category, and how is that determined? So generally, we take 10 times the number of measures that are expected or required. So, for a lot of clinicians, that'll be six measures times 10 is 60 points. If you happen to be assessed on the All-Cause Readmission measure, then you would have seven measures, and that would be 70 points. If you're using the Web Interface, even though you submit 10 measures, only eight of those are scored. So, it'd be 80 points. And if you're submitting a specialty measure set, then it might be fewer than six measures in that set, and so the denominator might be less than 60. But one question that we get commonly is, "Well, what if I can't find enough measures to submit, or what if I can't submit all the measures in a specialty set? Now, then what happens?" Well, in MIPS, you're expected to report on measures that are applicable to your practice, that means they’re relevant to the patients that you see and the care you deliver, up to the required number of six measures. Those measures need to be available to you,

meaning you have to have patients that you could report for those measures. So, as long as you have enough measures that meet that criteria, we would expect you to report all six. However, if you are unable to find that number of measures, meaning either you have measures but you don't have patients for those measures, or the measures are not relevant to your practice, it is possible that the six measure requirement can be reduced for scoring purposes. If you submit fewer than the required number of measures, we have a process known as EMA, which is the Eligible Measures Applicability process where we first look to see whether there are other clinically related measures to the ones you did submit, and then whether you had sufficient patients for those additional measures. If we identify additional measures under EMA, then those measures would be scored at zero points and they would still be in your denominator for Quality. However, if we are either unable to identify additional measures, or the ones that we identify, you don't have patients for, then your denominator could be reduced to reflect an insufficient number of applicable measures. So, we have more details on the EMA process in a resource on our QPP Resource Library under eligible measures applicability, and I encourage you to review that.

Next slide. So, this next slide will show the way scoring works for small practices. And so, it's basically the same as what I just showed with the exception of the small practice bonus in the numerator. So, you would get an additional six points added to your numerator as long as you submitted at least one quality measure. But otherwise, the calculation is the same and the improvement percent score is added to the end to get your total score for the Quality category.

Next slide. All right, and so my last slide here is just a brief mention of a new scoring option that's available for some clinicians in MIPS. It's our facility-based measurement option. So, beginning this year, we will identify clinicians and groups that are eligible for facility-based scoring. These clinicians and groups will have the option to use a facility-based measurement score for both the Quality and the Cost performance categories, making use of a hospital value-based purchasing score from a hospital to which they have been attributed. So, in order to make use of this scoring, you do need to be identified as facility-based. That means you need to have at least 75% of your Medicare services in a hospital-based setting. You need to be attributed to a facility, a hospital with an HVBP score for the 2019 performance period, and then this score must be higher than any score derived from data you submitted for the Quality and Cost category. So, this is an option that will be available to some clinicians, but we will automatically be calculating this to determine if it is applicable, and we are planning a preview period so that clinicians will know whether they meet the definition of facility-based, and if so, which hospital they are attributed to. So, I will stop there and turn it over to Adam to wrap up with some resources to give you further help.

All right, thanks, David. We're going to charge forward to slide 44. I'll go through these rather quickly. I know we are getting closer to the bottom of the hour, so we can take just a couple of questions today, but I do just want to make sure to call out, as Sophia mentioned earlier, the Quality Payment Program website, qpp.cms.gov. Under the Resource Library, there are a number of different fact sheets, supporting documentation. We have our quality benchmarks available, so all of that is listed in the Quality Payment Program Resource Library. Also encourage you all if you haven't done so already to check out our "Explore Measures" page on qpp.cms.gov. Not only can you take a look at the various measures that are available for 2019 under the Quality

performance category, but you can also take a look at the other performance categories, as well. So highly recommend both of those resources, but just going to qpp.cms.gov in general, just kind of searching around, there's a lot of really great information to help you get started.

Speaking of helping you get started, on slide 45, I do just want to quickly touch on our free technical assistance that is available to each clinician who is participating in this program. We do have this broken out based on practice size because we know that there are different needs for each practice. So, if you are in a smaller practice, I highly encourage you to reach out to the small, under-served, and rural supports initiative. For our larger practices, we have our quality innovation networks and quality improvement organizations. Both are fantastic resources, and of course, that's absolutely no cost to you. Again, check out our Quality Payment Program website. We also have the Quality Payment Program service center that is on standby to answer many of your questions. I know we're getting a number of questions coming in through the chat, so if we don't get to answer your question today, please feel free to reach out to the service center and we'll get you that answer. Okay, with that, we have a couple minutes remaining. I do want to take just a couple of callers. Again, just a few. So, I'm going to turn it back over to the operator to walk us through how you can get in line for the Q&A.

In order to ask a question, you will need to please dial in at 1-877-388-2064. Again, that number is 1-877-388-2064. When prompted, please enter the ID number 6288375. Again, that's 6288375. Join the conference. Once you join the conference, please press star-1 to ask your question. Again, that is star-1 once you join the conference. And we do have an audio question from Christina Casconti.

Okay, great.

Hi, everyone. Good afternoon. I was calling because we have a large PIN group that we submit quality data for, and there's a small subset of physicians that recently joined that tax ID group, and they're requesting for their own additional submission to a registry for their specialty quality measures. Is this possible to do, considering they're part of the larger PIN group? Thank you.

So, thank you for the question, and it's a great question. We're kind of scratching our heads here. Could also be the knit caps that we wore into work today, but that's another story. No, just kidding. They can report -- Here's the consolation. So, they definitely can report and they would get feedback from the registry, which would be a good thing for them 'cause they can see how they're doing on their own metrics. We'd have to double check, though, to see if -- in other words, if their score were higher than your group's score, we'd have to see whether they would get that, or whether or not they would just be assigned a group score. So that's something I would suggest you submit to the help desk, and we will research it and get a better answer for you.

And you can flag that you spoke with us on this webinar. That way we know we can track the answer back to you.

Perfect. Thank you guys so much.

Thank you. Next call.

Your next question is from Deb Needy.

Hi, thank you. My question is on slide 26 talking about submitting claims versus other means. We actually are paper charts now, so we're doing by claims. We will be starting in EHR this summer. I guess from what I understand, they won't pull from both. They're going to pick and choose. If we submit more by claims, they'll use those, or if we submit it through our EHR, they'll pick those. They won't combine those. For instance, one measure, they won't look at all of them and make sure that all of that data was collected?

One measure. So, thank you for the question. That is correct. Unfortunately, we can't say, "Oh, okay, so for practice, one, two, three, four," you know, "Hey, through May, they're claims, and then starting in June, they're EHR, so let's add the patients from claims together with the EHR." For a host of reasons, we couldn't do that, not the least of which there may be redundancy and result in patients that are seen more than one time during the year might be counted more than once when the measure may only call for accounting for that patient a particular time. So that would be difficult for us to do. We don't really look at and say, "Well, hey, from claims on measure number 22 they reported 100 times, but on their EHR, it said they had 122. Okay, we'll take the 122." We don't do that either. What we do look for is a full year's reporting. So, we can look at different submission methods. We can look at, you know, if you submitted, let's say, through an EHR for the full year and through claims for a full year, we could look at that and give you credit for the higher of the two -- performance, that is. But what we can't do is we can't combine the two methods 'cause we wouldn't know.

Thank you.

Okay, thank you.

Your next question is from Erin Hawks.

Yes, hi. We work with facility-based providers. So, let's say mostly emergency room providers, and I heard you mention that there's going to be a preview period of who is considered a facility-based provider. So, I'm wondering when will that be, and how will we know what the hospital's score was? So, I can answer -- I'll try to answer that first question. We may have to circle back on the second piece of that. So, we are working through facility-based preview right now. We're hoping to have that -- We anticipate having that as part of – a lookup tool that we have online. Still working through some of that, so we hope to have that available and updated soon. So, we'll push out that notification, that update, when that information is available through the QPP, the Quality Payment Program, listserv. And the second part of your question, I don't think we have our specific subject matter expert on for that, so we may just have to take that one back and follow up.

Okay, yeah, because based on the hospital's score, I think that's how groups will decide whether they want to go with a facility-based option or go ahead and continue to participate, like, through a registry how they normally have. Does that make sense?

No, absolutely. It makes complete sense, and if you want, if you'd just send that to us through the service center, and again, flag it for us that you talked to us on the webinar, we'll be able to circle back with you.

Okay, thank you.

Thank you. We're going to take one more question, folks. I'm sorry, we are running tight on time at this point.

Our last question for today will be Gail Reese.

Hi. Thank you so much for taking my question, and I apologize because I've tried to word this a few different ways. So, I work for a specialty organization, and the number of measures that are available are limited, and I understand that they just need to report however many measures are available to them, but for example, if they would like to report via claims, as many of our members do, and there are only three measures that they can report via claims, but they could ostensibly report, you know, three additional claims via other submission mechanisms, is there now an expectation of CMS that they're supposed to fully participate by reporting via multiple submission mechanisms if that's the only way that they can get to six, or does CMS consider full reporting within a singular submission mechanism to be full participation so long as those are the only available measures to them in that submission mechanism? Does that make sense?

Yeah, yeah. This is David, and thank you for that question. Yeah, so we made the multiple submission mechanisms option available in Year Three for those clinicians who, you know, want to report more measures, but they were limited in the first two years because they could only be scored on one collection type at a time. So, we did that to introduce flexibility, but it was not meant to impose a requirement that you had to sort of report on all possible data collection types. So, if you submitted measures just using claims, that's all that we would score, and we would, assuming that you had fewer than six measures, we would apply the eligible measure's applicability just to the claims set. We wouldn't expect you to have looked beyond that. However, if you did submit using more than one collection type, we would apply that across all that you submitted.

Great. Thank you so much.

Okay, fantastic. Well, thank you, everyone, so much. We do have to end today. Again, if you do have additional questions, feel free to send them over to the service center, and we'll do our best to try to get them answered. We appreciate your time. Be on the lookout for some future webinars. Again, please sign up for that Quality Payment Program listserv and we'll talk to you all again soon. Thank you.

Thank you. This concludes today's conference. You may now disconnect. Speakers, hold the line.