Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Scoring 101 Guide for the 2019 Performance Year

Updated 1/23/2020

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HOW TO USE THIS GUIDE

How to Use This Guide

Please Note: We developed this guide to provide a general summary about MIPS scoring. ***This guide does not address MIPS APM policies or the APM scoring standard.*** *Additionally, this guide was prepared for informational purposes only and is not intended to grant rights, impose obligations, or take the place of either the statute or regulations. We urge you to review the specific statutes, regulations, and other relevant materials for their complete and accurate contents.*

In this guide, we use the term "clinician" for MIPS eligible clinicians.

Table of Contents

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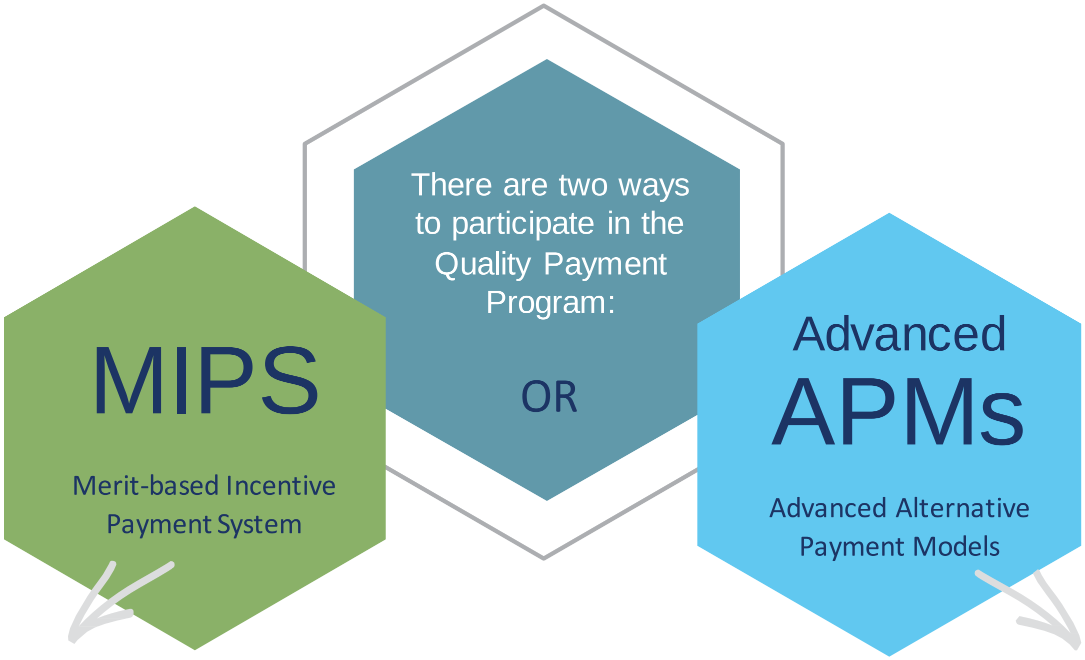
Hyperlinks

Hyperlinks to the [QPP website]() are included throughout the guide to direct the reader to more information and resources.

OVERVIEW

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. By law, MACRA requires CMS to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:



There are two ways to participate in the Quality Payment Program:

MIPS

Merit-based Incentive Payment System

OR

Advanced APMs

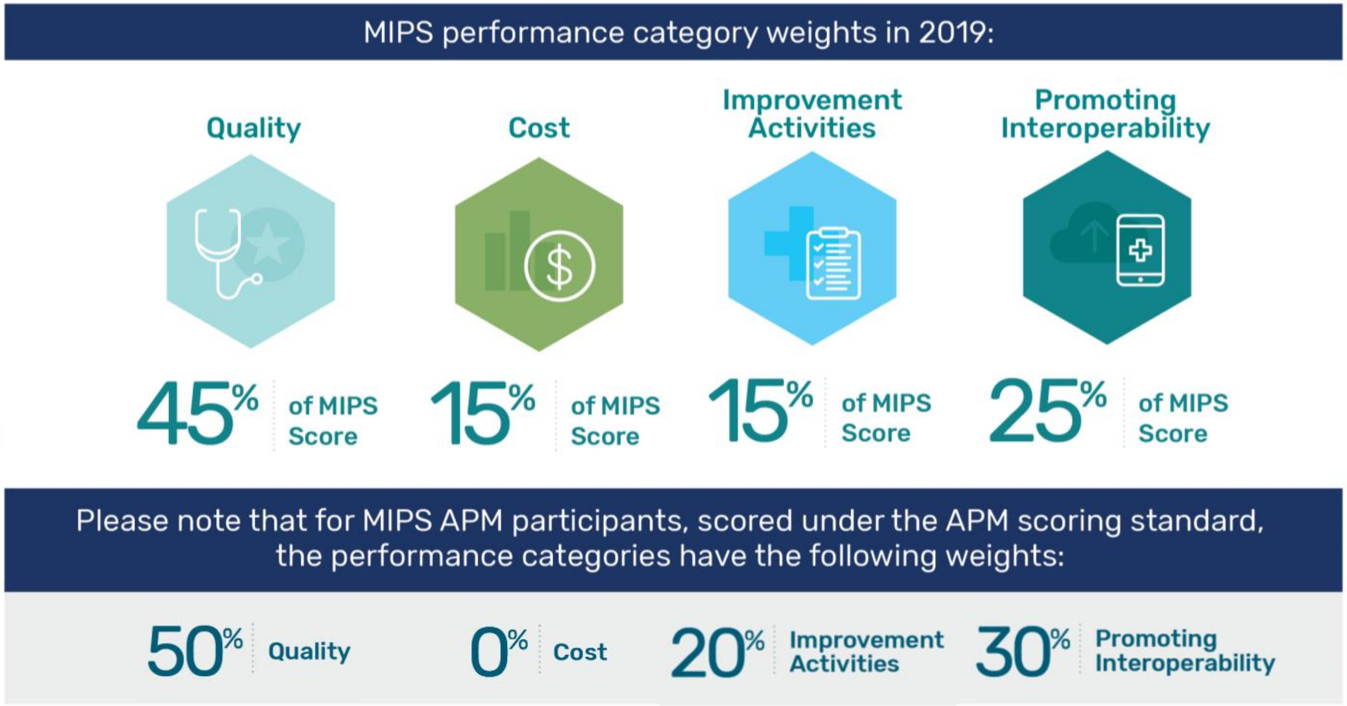
Advanced Alternative Payment Models

If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

What is the Merit-based Incentive Payment System (MIPS)?

Under MIPS, there are **4** performance categories that can affect future payments for covered professional services furnished by MIPS eligible clinicians. Each performance category is scored by itself and has a specific weight, and your performance in these categories contributes to your MIPS final score. The payment adjustment assessed for MIPS eligible clinicians is based on the final score.



MIPS performance category weights in 2019:

Quality	Cost	Improvement Activities	Promoting Interoperability
45% of MIPS Score	15% of MIPS Score	15% of MIPS Score	25% of MIPS Score

Please note that for MIPS APM participants, scored under the APM scoring standard, the performance categories have the following weights:

Quality	Cost	Improvement Activities	Promoting Interoperability
50%	0%	20%	30%

To learn more about how to participate in MIPS:

- *Visit the MIPS Eligibility and Individual or Group Participation web pages on the Quality Payment Program website.*
- *View the 2019 MIPS Participation and Eligibility Fact Sheet.*
- *Check your current participation status using the QPP Participation Status Tool.*

In certain circumstances, one or more of the performance categories may be reweighted to 0 percent. More information on reweighting, including for Extreme and Uncontrollable Circumstances, is provided in each category section and in Appendix B.

This guide does not address the APM Scoring Standard, which has different performance category weights.

Getting Started: New MIPS Terms

We've revised our terminology to better reflect how data collection and submission actually works.

Collection Type*

Collection Type is a set of quality measures with comparable specifications and data completeness criteria, identified as:

- Electronic clinical quality measures (eCQMs);
- MIPS clinical quality measures (CQMs) (formerly referred to as "Registry measures");
- Qualified Clinical Data Registry (QCDR) measures;
- Medicare Part B claims measures;
- CMS Web Interface measures;
- Consumer Assessment of Healthcare, Providers and Systems (CAHPS) for MIPS survey measure; and
- Administrative claims measures.

Submitter Type

Submitter Type is the MIPS eligible clinician, group, or third-party intermediary acting on behalf of a MIPS eligible clinician or group, that submits data on measures and activities.

Submission Type**

Submission Type is the mechanism by which the submitter type submits data to CMS:

- Direct (transmitting data through a computer-to-computer interaction, such as an Application Program Interface, or API);
- Log in and upload;
- Log in and attest;
- Medicare Part B claims; and
- CMS Web Interface.

Beginning in 2019, CMS will aggregate measures and activities submitted via multiple submission types for a single performance category. Please note that a measure or activity will only be counted once, even if submitted via multiple collection types or submission types. Additional information will be available prior to the data submission period.

* The term "Collection Type" is unique to the Quality performance category and does not apply to the other three performance categories.

** There is no submission type for cost data because the data is collected and calculated by CMS from administrative claims data submitted for payment.

MIPS QUALITY PERFORMANCE CATEGORY

MIPS Quality Performance Category

What are the Quality Performance Category Data Submission Requirements?

You can select from **more than 250** available quality measures finalized for Year 3 (2019). You will need to collect and submit data for each quality measure for the entire calendar year of 2019.

With the exception of CMS Web Interface measures, CMS will aggregate quality measures collected through multiple collection types beginning with the 2019 performance period. If the same measure is collected via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring.

Quality

45% of MIPS Score

To meet the Quality performance category requirements, a MIPS eligible clinician, group, or virtual group must:

Submit 6 quality measures for the 12-month performance period:

- 1 of these 6 must be an outcome measure OR another high priority measure in the absence of an applicable outcome measure.
- The CAHPS for MIPS survey measure counts as 1 of the 6 measures for registered groups and virtual groups. The CAHPS for MIPS survey measure is a patient experience measure and can be counted as a high priority measure if there are no applicable outcome measures.

Instead of picking 6 measures from the MIPS quality measures list, you can choose to do the following:

- Submit at least 6 quality measures from a defined specialty measure set. 1 of the measures must be an outcome measure OR another high priority measure in the absence of an applicable outcome measure. If the specialty measure set has fewer than 6 measures, you need to submit all measures within that specialty set.
- Submit all quality measures included in the CMS Web Interface, a collection type available to registered groups and virtual groups with 25 or more eligible clinicians. The CAHPS for MIPS survey measure can be submitted as an additional high priority measure.
- Submit 6 measures through a Qualified Clinical Data Registry (QCDR). QCDRs are not limited to MIPS measures and can use other measures approved by CMS.

What are the Quality Performance Category Data Submission Requirements?

In addition to their submitted measures, groups and virtual groups with 16 or more eligible clinicians will be scored on the All-Cause Hospital Readmission measure if they meet the case minimum of 200 patients for the measure. If the group or virtual group falls below the case minimum, then the All-Cause Hospital Readmission measure won't be calculated or scored, and MIPS eligible clinicians will only be scored on the submitted measures. (There are no data submission requirements for this measure.)

Are the Quality Performance Category Data Submission Requirements Different for the CMS Web Interface?

Yes. Registered groups and virtual groups using the CMS Web Interface will submit data for all the required quality measures in the CMS Web Interface for a full year, even if they are also submitting the CAHPS for MIPS measure.

Did you know? In 2019, there are a total of 10 measures reported through the CMS Web Interface, a reduction from the 15 measures required in 2018.

What is Facility-based Scoring?

Beginning in the 2019 performance period, CMS will identify MIPS eligible clinicians, groups, and virtual groups that are eligible for facility-based scoring. These clinicians may have the option to use facility-based measurement scores for their Quality and Cost performance category scores.

Facility based scoring will be used for your Quality and Cost performance category scores when:

You are identified as facility-based at the level you intend to participate;

AND

You are attributed to a facility with a FY 2020 Hospital Value-Based Purchasing (VBP) Program score at the level you intend to participate;

AND

If you choose to submit Quality measures for MIPS, the Hospital VBP score results in a higher score than the MIPS Quality measure data you submit and MIPS Cost measure data we calculate for you.

For example, if your practice is participating as a group (submitting aggregated data for the TIN), you would need to look for the facility-based designation and facility attribution at the *Practice Level* on qpp.cms.gov.

For more information on Facility-based Measurement, please review the [2019 Facility-based Measurement Fact Sheet]() and [Facility-based Preview FAQs]().

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

Are you submitting your quality measures through the CMS Web Interface? Skip ahead.

How are measures assessed in the Quality performance category for Year 3 (2019)?

When you submit measures for the MIPS Quality performance category, your performance on each measure is assessed against a benchmark to see how many points you earn for the measure.

Quality benchmarks are differentiated by collection type. There may be different benchmarks for the same measure if it can be reported through multiple collection types.

- eCQMS
- Medicare Part B Claims measures (small practices only)
- MIPS CQMs
- QCDR measures

Whenever possible, we create historical benchmarks and post them on the QPP Resource Library at the start of the performance period. Historical benchmarks for each collection type are based on performance data from a baseline period, the 12-month calendar year that is 2 years prior to the applicable performance period. The historical benchmarks for the 2019 MIPS performance period were established from quality data submitted for the 2017 MIPS performance period.

For more information about 2019 quality benchmarks, please refer to the 2019 Quality Benchmark zip file on the QPP Resource Library.

The All-Cause Hospital Readmission measure, calculated via administrative claims, is also scored against a benchmark. We are currently constructing the historical benchmark for PY 2019 and will update the 2019 benchmark file when it's available.

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

What if a quality benchmark doesn't have a historical benchmark?

For a measure without a historical benchmark, we will try to calculate a benchmark following the submission period based on 2019 performance data on those measures.

Performance period benchmarks can be calculated when 20 or more individuals, groups, or virtual groups submit the measure via the same collection type where the measure:

- Meets or exceeds the minimum case volume of 20 eligible cases (has enough data for it to be reliably measured);
- Meets or exceeds the 60 percent data completeness criteria; and
- Has a performance rate greater than 0 percent (or less than 100 percent for inverse measures).

Individuals, groups, and virtual groups must be included in MIPS (i.e. are not voluntarily reporting) for their data to be used in the creation of a benchmark.

How are measures scored?

If a measure can be reliably scored against a benchmark, it means:

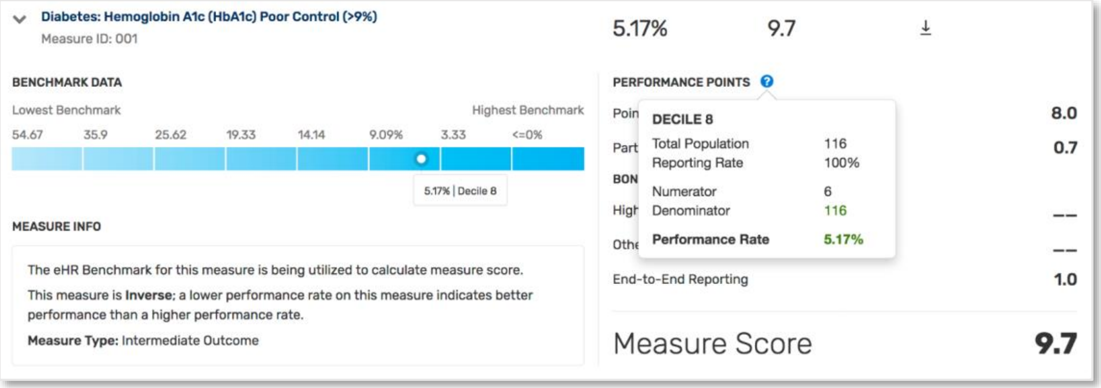
- A benchmark is available; and
- The volume of cases you've submitted is sufficient (> 20 cases for most measures; > 200 cases for the hospital readmission measure); and
- You've met data completeness requirements (submitted data for at least 60 percent of the denominator eligible patients/instances).

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

Measure Achievement Points

Measure achievement points are earned based on a measure’s performance in comparison to a benchmark, exclusive of bonus points.

- You will continue to receive between 3 and 10 achievement points for quality measures that can be reliably scored against a benchmark.



Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
Measure ID: 001

5.17% 9.7

BENCHMARK DATA

Lowest Benchmark							Highest Benchmark
54.67	35.9	25.62	19.33	14.14	9.09%	3.33	<=0%

5.17% | Decile 8

MEASURE INFO

The eHR Benchmark for this measure is being utilized to calculate measure score.

This measure is **Inverse**; a lower performance rate on this measure indicates better performance than a higher performance rate.

Measure Type: Intermediate Outcome

PERFORMANCE POINTS

Poin	8.0
Part	0.7
BON	
High	--
Othe	--
End-to-End Reporting	1.0
Measure Score	9.7

DECILE 8

Total Population	116
Reporting Rate	100%
Numerator	6
Denominator	116
Performance Rate	5.17%

Disclaimer: Whenever possible, we’ve incorporated images from the Performance Year 2018 QPP submission system to connect scoring policies with the submission experience. Keep in mind that these images may not exactly represent what you will see in the Performance Year 2019 QPP submission system.

  - **Exception:** There are specified, topped out measures that are capped at 7 points. (These measures are identified on the 2019 MIPS Quality Historical Benchmarks Excel file – see column Q – in the [2019 Quality Benchmark zip file](#).)

- You will continue to earn 3 points for quality measures that meet data completeness requirements but do not have a benchmark or meet the case minimum.
- You will continue to earn 1 point for quality measures that do not meet the data completeness requirements (generally 60 percent for 2018).
  - **Exception:** Small practices will continue to earn 3 points for quality measures that don’t meet data completeness requirements.
- If you don’t submit at least 1 available measure, you will receive 0 points in this category unless you can be scored on the All-Cause Hospital readmission measure (or qualify for reweighting).

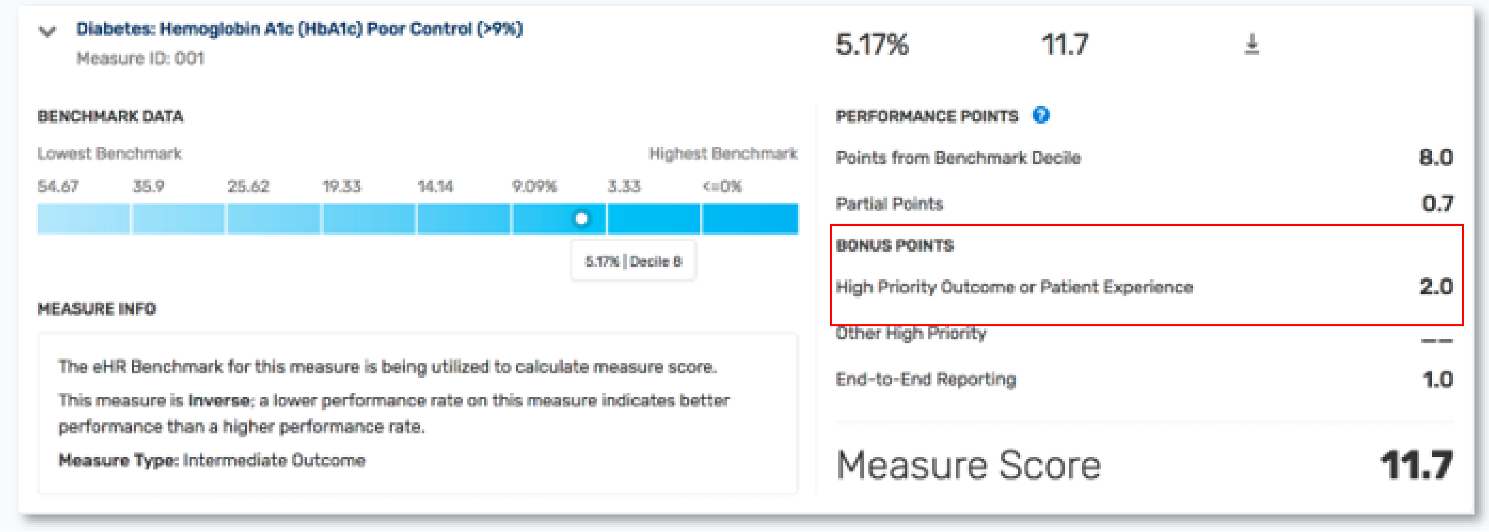
Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

Measure Bonus Points

You can earn bonus points in the Quality performance category in addition to measure achievement points.

You can earn measure bonus points if you:

- Submit additional outcome, patient experience, or other high priority measures beyond the 1 required
  - 2 bonus points for each additional outcome and patient experience measure that meet case minimum and data completeness requirements and have a performance rate > 0 percent



Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

Measure ID: 001

5.17% 11.7

BENCHMARK DATA

MEASURE INFO

The eHR Benchmark for this measure is being utilized to calculate measure score.

This measure is **Inverse**; a lower performance rate on this measure indicates better performance than a higher performance rate.

Measure Type: Intermediate Outcome

PERFORMANCE POINTS	
Points from Benchmark Decile	8.0
Partial Points	0.7
BONUS POINTS	
High Priority Outcome or Patient Experience	2.0
Other High Priority	--
End-to-End Reporting	1.0
Measure Score	**11.7**

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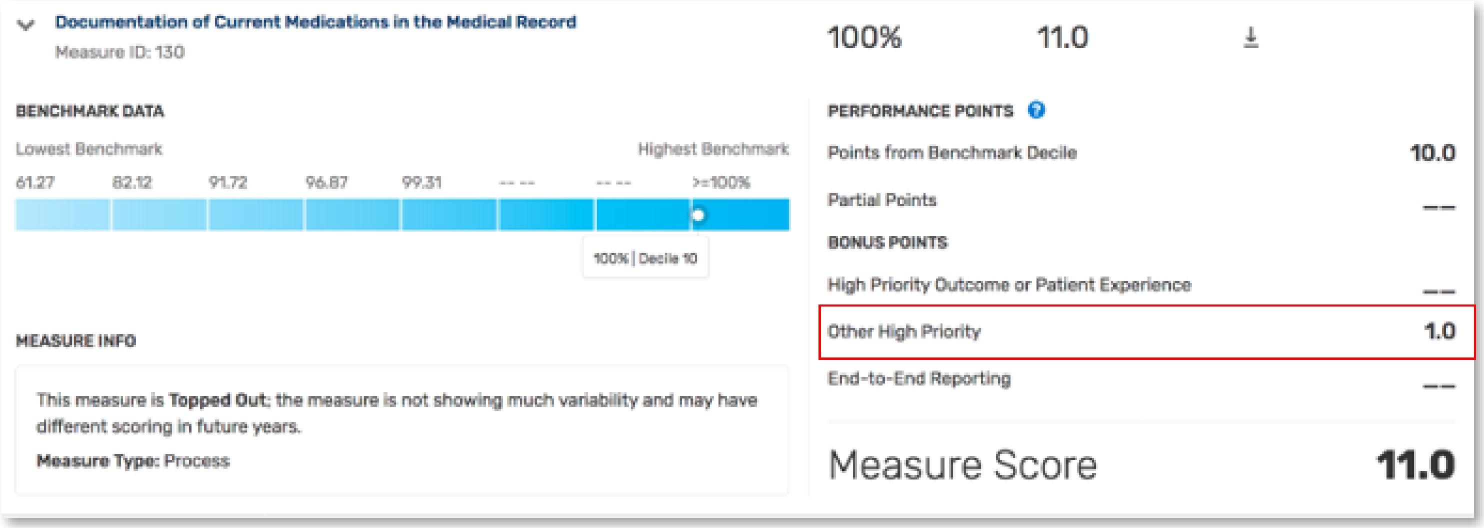
Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

Measure Bonus Points *(continued)*

- 1 bonus point each for other high priority measures that meet case minimum and data completeness requirements and have a performance rate > 0 percent



Documentation of Current Medications in the Medical Record
Measure ID: 130

100% 11.0

BENCHMARK DATA

Lowest Benchmark — Highest Benchmark

61.27 82.12 91.72 96.87 99.31 -- -- -- -- >=100%

100% | Decile 10

MEASURE INFO

This measure is **Topped Out**; the measure is not showing much variability and may have different scoring in future years.

Measure Type: Process

PERFORMANCE POINTS

Points from Benchmark Decile	10.0
Partial Points	--
BONUS POINTS	
High Priority Outcome or Patient Experience	--
Other High Priority	1.0
End-to-End Reporting	--
Measure Score	**11.0**

Disclaimer: Whenever possible, we've incorporated images from the Performance Year 2018 QPP submission system to connect scoring policies with the submission experience. Keep in mind that these images may not exactly represent what you will see in the Performance Year 2019 QPP submission system.

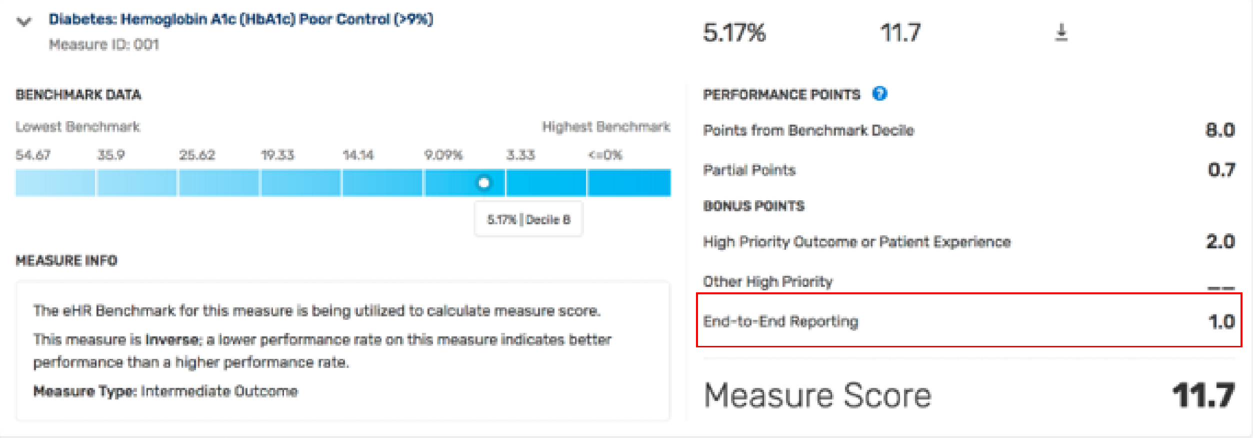
Did you know?

- Additional outcome or high priority bonus points are capped at 10 percent of the Quality performance category denominator (or the total number of available measure achievement points)
- MIPS eligible clinicians that submit the same additional outcome or high priority measure through multiple collection types will receive the bonus point(s) once.

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

Measure Bonus Points *(continued)*

- Use Certified EHR Technology (CEHRT) and meet end-to-end electronic reporting requirements
  - 1 bonus point for each measure that meets end-to-end electronic reporting criteria. (The measure doesn't need to meet case minimum or data completeness requirements)



Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
Measure ID: 001

5.17% 11.7

BENCHMARK DATA

MEASURE INFO

The eHR Benchmark for this measure is being utilized to calculate measure score.

This measure is **Inverse**; a lower performance rate on this measure indicates better performance than a higher performance rate.

Measure Type: Intermediate Outcome

PERFORMANCE POINTS	
Points from Benchmark Decile	8.0
Partial Points	0.7
BONUS POINTS	
High Priority Outcome or Patient Experience	2.0
Other High Priority	—
End-to-End Reporting	1.0
Measure Score	**11.7**

Disclaimer: Whenever possible, we've incorporated images from the Performance Year 2018 QPP submission system to connect scoring policies with the submission experience. Keep in mind that these images may not exactly represent what you will see in the Performance Year 2019 QPP submission system.

Did you know?

- End-to-end bonus points are capped at 10 percent of the Quality performance category denominator (or the total number of available measure achievement points).
- When reporting a measure with an eCQM equivalent, you must submit the eCQM (extracted from your 2015 Edition CEHRT) to earn the end-to-end bonus points.
- End-to-end bonus points are automatically applied to eCQMs and can be applied to MIPS CQMs without an eCQM equivalent if the submission indicates that the measure(s) meets end-to-end electronic reporting criteria.
- Please see Appendix C for more information on end-to-end submissions.

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

What if I submit more than 6 measures?

If you submit more than 6 measures, only 6 of those measures will contribute measure achievement points to your Quality performance category score. However, we will include any bonus points from the remaining measures, as long as you haven't exceeded the 10 percent cap for the applicable bonus.

When determining which measures are included in the top 6:

- We will select the highest scoring outcome measure.
    - If you don't have an outcome measure available, then we will select the highest scoring high priority measure.
- We will then select the next 5 highest scoring measures.
- If you don't submit an outcome or high priority measure, we will select your 5 highest scoring measures and you will receive a score of 0/10 for the missing outcome or high priority measure unless the Eligible Measure Applicability (EMA) process finds you didn't have one available.

Remember that scoring is determined by comparing the performance rate to the measure's benchmark. If you submit 2 measures, each with an 85 percent performance rate, one may earn 7 points while the other earns 10 points, based on the benchmarks for each measure.

When there are multiple measures with the same score, we will select measures for the top 6 based on the measure ID (in ascending order).

- **Example:** You submit 7 measures, and your 2 lowest scoring measures (after the outcome measure) were the Colorectal Cancer Screening and Screening Colonoscopy Adenoma Detection Rate measures, both earning 3 points. The Colorectal Cancer Screening measure will be included in the top six because its measure ID (113) has a lower value than the Adenoma Detection Rate measure (343).

If you submit the same measure through multiple collection types—e.g. as a Medicare Part B claims measure and as an eCQM—we will select the higher scoring version of the measure based on achievement points. Under no circumstances will two versions of the same measure count towards your Quality performance category score.

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

How many measure points can I earn in the Quality performance category?

Clinicians, groups, and virtual groups who are not scored on the All-Cause Hospital Readmission measure can earn a maximum of 60 measure achievement points in the Quality performance category.

Groups and virtual groups who are scored on the All-Cause Hospital Readmission Measure can earn a maximum of 70 measure achievement points in the Quality performance category.

Maximum Points by Reporting Level

Individuals

60 POINTS

Groups/Virtual Groups

60 POINTS
If the readmission measure does not apply

70 POINTS
For 6 measures + 1 readmission measure

80 POINTS
for CMS Web Interface measures

90 POINTS
for CMS Web Interface measures + 1 readmission measure OR CAHPS for MIPS Survey

100 POINTS
for CMS Web Interface measures + 1 readmission measure AND CAHPS for MIPS Survey

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

Can the denominator (maximum number of points) be lower than 60 points?

Yes, under certain circumstances your denominator (10 x the number of measures you're required to report) may be lowered.

IF…	THEN…
You submit a complete specialty measure set that has less than 6 measures.	We will lower the denominator by 10 points for each measure that isn't available.
You submit fewer than 6 Medicare Part B claims measures or fewer than 6 MIPS CQMs AND the EMA process determines no additional measures were available. ***How?*** *We compare the measures you submitted with a predefined list of clinically related measures.*	We will lower the denominator by 10 points for each measure that isn't available. ***NOTE:*** *If we find additional clinically related measures that you didn't report, then we won't remove those measures from the maximum number of points available for the Quality performance category and you will earn a score of 0 out of 10 for each of these measures.*
New for 2019: You submit a measure(s) significantly impacted by clinical guideline (or other) changes that CMS believes may result in patient harm or misleading results.	We will lower the denominator by 10 points for each impacted measure. ***Why?*** *So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification.*
New for 2019: Your group registers for the CAHPS for MIPS survey but does not meet the minimum beneficiary sampling requirements AND submits fewer than 6 measures.	We'll lower the denominator by 10 points to account for your inability to report the CAHPS for MIPS survey measure.

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

What are the steps to score Medicare Part B claims measures, QCDR measures, eCQMs, and/or MIPS CQMs?

1. **Check to see if the 60 percent data completeness requirement was met.**
   a. If Yes – continue to step 2
   b. If No – assign 3 points to measures submitted by a small practice, or 1 point to all others
2. **Check to see if 20 case minimum requirement was met.**
   a. If Yes – continue to step 3
   b. If No – assign 3 points
3. **Check to see if there is a benchmark associated with the collection type.** (We'll attempt to create a performance period benchmark if there is no historical benchmark.)
   a. If Yes – continue to step 4
   b. If No – assign 3 points
4. **Assign achievement points based on the benchmark.** Achievement points are calculated by mapping the performance rate to the benchmark for the collection type.
   a. Determine the decile that the performance rate falls in and assign points
5. **Calculate and add any bonus points.**
   a. The measure(s) doesn't/don't have to be in the "top 6" to earn bonus points
   b. The high priority/outcome bonus measure(s) has/have to meet the case minimum and data completeness requirements and have a performance rate > 0 percent
   c. The end-to-end bonus measure(s) does/do not have to meet the case minimum and data completeness requirements
   d. Each category of bonus points (high priority and end-to-end) is capped at 10 percent of the denominator of the Quality performance category score

Repeat steps 1 – 5 for each measure.

Submitting Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs

What are the steps to score Medicare Part B claims measures, QCDR measures, eCQMs, and/or MIPS CQMs? *(continued)*

We will pick the top 6 measures, including 1 outcome measure (or, if no outcome measure applies a high priority measure), based on the highest number of achievement points for each measure.

- If no outcome or high priority measure is submitted, you will only be scored on 5 measures and you will receive 0 out of 10 points for the unsubmitted outcome measure.
- If you report the same measure through multiple collection types, we will only include one version of the measure in your Quality performance category score.

Appendix A gives you an example of how to find a benchmark, determine achievement points, and pick the top 6 measures based on the number of points.

Skip ahead to review how we calculate the Quality performance category score.

Submitting CMS Web Interface Measures

REMINDER: This guide focuses on scoring for MIPS and does not address scoring for Accountable Care Organizations or clinicians under the APM scoring standard.

How are Web Interface measures assessed in the Quality performance category for Year 3 (2019)?

When you submit measures through the CMS Web Interface, your performance on each measure is assessed against a benchmark to see how many points you earn for the measure. Groups and virtual groups submitting their quality measures through the CMS Web Interface will be assessed against benchmarks from the Medicare Shared Savings Program.

NOTE: CMS Web Interface measures cannot be combined with other collection types other than the CAHPS for MIPS survey measure.

The All-Cause Hospital Readmission measure, calculated via administrative claims, is also scored against a benchmark. We are currently constructing the historical benchmark for PY 2019. We will update the 2019 benchmark file when it's available.

What if a CMS Web Interface measure doesn't have a benchmark?

Unlike other collection types, we will not attempt to calculate a performance period benchmark if there isn't an existing benchmark. CMS Web Interface measures without an existing benchmark do not count toward your Quality performance category score, as long as data completeness requirements are met.

Submitting CMS Web Interface Measures

How are CMS Web Interface measures scored?

Measure Achievement Points

Measure achievement points are based on your performance on a measure in comparison to a benchmark, exclusive of bonus points.

3 – 10 points	**0** (0 out of 10 points)	**0** (0 out of 10 points)	**N/A** (0 out of 0 points)	**N/A** (0 out of 0 points)
You will continue to receive between 3 and 10 achievement points for Quality measures that meet case minimum and data completeness requirements, and that can be scored against a benchmark.	You will continue to receive 0 points (0 out of 10) for measures that are not reported.	You will continue to receive 0 points (0 out of 10) for measures that do not meet data completeness requirements.	CMS Web Interface measures with fewer than 20 beneficiaries in the sample will not be scored and will be excluded from the quality denominator as long as data completeness requirements are met.	CMS Web Interface measures without an existing benchmark (or designated as "pay-for-reporting" under the Shared Savings Program) will not be scored and will be excluded from the quality denominator as long as data completeness requirements are met.

If you don't report at least 1 measure that meets data completeness requirements, you will receive 0 points in this category unless you can be scored on the All-Cause Hospital Readmission measure (or qualify for reweighting).

Submitting CMS Web Interface Measures

Measure Bonus Points

You can earn 1 bonus point per CMS Web Interface measure submitted according to Web Interface **end-to-end electronic reporting** criteria. For the 2019 performance period, this means submitting data collected in your CEHRT directly to CMS via the Web Interface Application Programming Interface (API) or Excel upload.

Did you know?

- These bonus points are capped at 10 percent of the Quality performance category denominator (or the total available measure achievement points).
- We discontinued bonus points for reporting high priority measures required by the CMS Web Interface, beginning with the 2019 performance period.
- Groups and virtual groups can still earn 2 bonus points for reporting the CAHPS for MIPS survey measure in addition to the CMS Web Interface measures.

Submitting CMS Web Interface Measures

How many measure points can I earn in the Quality category?

Groups and virtual groups submitting through the CMS Web Interface that are not scored on the All-Cause Hospital Readmission Measure and do not administer the CAHPS for MIPS survey can earn a maximum of 80 measure achievement points in the Quality performance category.

Groups and virtual groups submitting through the CMS Web Interface that are EITHER scored on the All-Cause Hospital Readmission Measure OR administer the CAHPS for MIPS survey can earn a maximum of 90 measure achievement points in the Quality performance category.

Groups and virtual groups submitting through the CMS Web Interface that are scored on BOTH the All-Cause Hospital Readmission Measure AND administer the CAHPS for MIPS survey measure can earn a maximum of 100 measure achievement points in the Quality performance category.

Maximum Points by Reporting Level

Individuals

60 POINTS

Groups/Virtual Groups

60 POINTS
If the readmission measure does not apply

70 POINTS
For 6 measures + 1 readmission measure

80 POINTS
for CMS Web Interface measures

90 POINTS
for CMS Web Interface measures + 1 readmission measure OR CAHPS for MIPS Survey

100 POINTS
for CMS Web Interface measures + 1 readmission measure AND CAHPS for MIPS Survey

Submitting CMS Web Interface Measures

Can the denominator (maximum number of achievement points) be lower than 80 points?

Yes, your denominator will be lowered if:

- You have fewer than 20 beneficiaries in a measure's sample (don't meet case minimum); AND
- You submit complete data for all of the beneficiaries in the sample (meet data completeness requirements).

If you meet data completeness requirements, then we'll lower the denominator (maximum number of points) by 10 points for each measure that doesn't meet case minimum.

Note: In regard to the CMS Web Interface measures, the maximum number of points that can be achieved is dependent on the number of measures scored. The CMS Web Interface measures that do not have a benchmark or are pay-for-reporting will not be scored as long as the data completeness requirements are met for such measures.

Submitting CMS Web Interface Measures

What are the steps to score CMS Web Interface measures?

1. **Check to see if data completeness requirements are met (measure is reported for the first 248 consecutively assigned beneficiaries in the sample or 100 percent of the sample if less than 248 beneficiaries).**
    a. If Yes – continue to step 2
    b. If No – assign 0 points to measure

2. **Check to see if the 20 case minimum requirement was met.**
    a. If Yes – continue to step 3
    b. If No – exclude from scoring (measure earns 0 out of 0 points)

3. **Check to see if there is a Shared Savings Program benchmark associated with the measure.**
    a. If Yes – continue to step 4
    b. If No – exclude from scoring (measure earns 0 out of 0 points)

4. **Assign achievement points based on the benchmark.** Achievement points are calculated by mapping the performance rate to Shared Savings Program benchmark.
    a. Determine the decile that the performance rate falls in and assign points

5. **Calculate and add any bonus points.**
    a. The measure must meet the case minimum and data completeness requirements and have a performance rate > 0 percent
    b. The end-to-end reporting category of bonus points is capped at 10 percent of the denominator of the Quality performance category score

Repeat steps 1 – 5 for each measure.

How is my Quality Performance Category Percent Score Calculated?

For clinicians, groups, and virtual groups that are not a small practice:

$$\text{Quality Performance Category Percent Score (Not to exceed 100\%)} = \frac{\text{Total Measure Achievement Points} + \text{Measure Bonus Points}}{\text{Total Available Measure Achievement Points*}} + \text{Improvement Percent Score}$$

For clinicians, groups, and virtual groups that are part of a small practice:

$$\text{Quality Performance Category Percent Score (Not to exceed 100\%)} = \frac{\text{Total Measure Achievement Points} + \text{Measure Bonus Points} + \text{Small Practice Bonus (6 points)}}{\text{Total Available Measure Achievement Points}} + \text{Improvement Percent Score}$$

*Total Available Measure Achievement Points = the number of required measures x 10

High priority and end-to-end electronic reporting bonus points are each capped at 10 percent of the denominator, which is the total possible points you could earn in the Quality performance category.

For example, if your Quality performance category denominator is 60 points, then you can earn up to 12 measure bonus points total, 6 points from each bonus category.

The small practice bonus will now be added to the Quality performance category, rather than in the MIPS final score calculation. 6 bonus points are added to the numerator of the Quality performance category for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure (these bonus points are available to small practices through individual, group, and virtual group participation).

Your Quality performance category percent score is then multiplied by the 45 percent Quality performance category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS final score.

The maximum score is 100 percent of the category weight.

How is my Quality Performance Category Percent Score Calculated?

What is Improvement Scoring?

MIPS eligible clinicians can earn up to 10 additional percentage points in the Quality performance category based on the rate of their improvement in the Quality performance category from the previous year. The improvement percent score—calculated at the category level and represents improvement in achievement from one year to the next— may not total more than 10 percentage points. If CMS can't compare data between two performance periods, or there is no improvement, the improvement score will be 0 percent. The improvement percent score cannot be negative.

Eligibility for these additional percentage points is determined by meeting the following criteria:

1. Full participation in the Quality category for the current performance period:

Submits 6 measures (with at least 1 outcome measure);

OR

Submits a complete specialty measure set (which may have fewer than 6 measures);

OR

Submits all the measures in the CMS Web Interface.

All submitted measures must meet data completeness requirements.

2. Data sufficiency standard is met meaning there is data available and can be compared:

There is a Quality performance category achievement percent score (the score earned by measures based on performance excluding bonus points) for the previous performance period (Year 2, 2018) and the current performance period;

AND

Data was submitted under the same identifier for the two consecutive performance periods, or CMS can compare the data submitted for the two performance periods (see Appendix E in the Quality Performance Category Fact Sheet for more information.)

Did you know? Improvement scoring is not available to clinicians who are scored in Quality under facility-based measurement for the 2019 MIPS performance period.

Scoring Example

A small practice, participating as a group, reports 2 Medicare Part B claims measures and 3 eCQMs. They also registered to administer the CAHPS for MIPS survey but were unable to administer the survey because they didn't meet the beneficiary sampling requirements.

Measure Type	Collection Type	Achievement Points	Bonus Points	Total Points
Outcome Measure #1	Medicare Part B Claims	7.8	N/A (Required)	7.8
Process Measure	Medicare Part B Claims	7.1	N/A	7.1
Process Measure	eCQM	6.9	1 (End-to-End)	7.9
Outcome Measure #2	eCQM	8.2	1 (End-to-End) 2 (High Priority Outcome)	11.2
Process Measure	eCQM	6.1	1 (End-to-End)	7.1
Totals		36.1	5	41.1

Because they are a small practice, they qualify for 6 bonus points and are not evaluated for the All-Cause Hospital Readmission measure.

They also qualify for improvement scoring because their achievement percent score showed improvement from last year. (More information about improvement scoring is available in the 2019 Quality Performance Category Fact Sheet.)

- Their 2019 achievement percent score = 36.1/50 = 72.2 percent
- Their 2018 achievement percent score = 62.2 percent
- The increase in their achievement percent score = 72.2 percent - 62.2 percent = 10 percent
- Their improvement percent score = (10 percent ÷ 62.2 percent) x 10 = 1.6 percent

MIPS Quality Performance Category

Scoring Example

Quality Performance Category Percent Score:

95.8%

=

36.1
Total Measure Achievement Points

+

5
Measure Bonus Points

+

6
Small Practice Bonus

―――――

50
Total Available Measure Achievement Points

= 94.2%

+

Improvement Percent Score

1.6%

Why is their denominator 50?
The group registered for, but did not meet, the sampling requirements for the CAHPS for MIPS survey measure and submitted less than 6 quality measures, so we reduced the denominator by 1 required measure.

Can the Quality Performance Category by Reweighted?

In the rare instance when there are no quality measures applicable and available to you, you won't be scored on this category and it will be reweighted to 0 percent of your final score. We anticipate that reweighting of the Quality performance category would be rare because there are quality measures applicable and available for most clinicians. Please contact the Quality Payment Program if this applies to you so that we can evaluate whether you have applicable and available quality measures to submit. You can contact the Quality Payment Program by phone (1-866-288-8292, TTY: 1-877-715-6222) or email (qpp@cms.hhs.gov.)

We continue to apply our extreme and uncontrollable circumstances policy to all performance categories.

Please refer to Appendix B for more information on category reweighting, including the extreme and uncontrollable circumstances policy.

MIPS COST PERFORMANCE CATEGORY

MIPS Cost Performance Category

Cost

15% of MIPS Score

What are the Cost Performance Category Data Submission Requirements?

We use Medicare claims data to calculate cost measure performance which means there are no additional data submission requirements for this performance category.

How are MIPS Cost Measures Scored?

For a cost measure to be scored, an individual MIPS eligible clinician, group, or virtual group must meet or exceed the case minimum for that cost measure. The table below outlines the 2019 case minimum and maximum amount of points that can be earned for each of the 10 MIPS cost measures.

MIPS Cost Measure	Case Minimum	Total Possible Measure Achievement Available
Total Per Capita Cost for All Attributed Beneficiaries (TPCC) Measure	20	10
Medicare Spending Per Beneficiary (MSPB) Measure	35	10
Elective Outpatient Percutaneous Coronary Intervention (PCI) Measure (Episode Group Type: Procedural)	10	10
Knee Arthroplasty Measure (Episode Group Type: Procedural)	10	10
Revascularization for Lower Extremity Chronic Critical Limb Ischemia Measure (Episode Group Type: Procedural)	10	10
Routine Cataract Removal with Intraocular Lens (IOL) Implantation Measure (Episode Group Type: Procedural)	10	10
Screening/Surveillance Colonoscopy Measure (Episode Group Type: Procedural)	10	10
Intracranial Hemorrhage or Cerebral Infarction Measure (Episode Group Type: Acute Inpatient Medical Condition)	20	10
Simple Pneumonia with Hospitalization Measure (Episode Group Type: Acute Inpatient Medical Condition)	20	10
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) Measure (Episode Group Type: Acute Inpatient Medical Condition)	20	10

MIPS Cost Performance Category

How are MIPS Cost Measures Assessed?

To assess your MIPS cost measure performance, we will:

- Establish a single, national benchmark for each cost measure based on the performance period (there are no historical benchmarks established for cost measures);
- Compare performance on each scored measure (expressed as a dollar amount) to the performance period benchmark(s); and
- Assign 1 to 10 achievement points to each scored measure based on that comparison. The amount of achievement points assigned to each measure is determined by identifying which benchmark decile range the individual or group's measure performance falls in between.

How Many Points Can I Earn in the Cost Performance Category?

Clinicians, groups, and virtual groups can earn a maximum of 100 achievement points in the Cost performance category, or 10 achievement points for each of the 10 cost measures. This amount of points is available only to individual clinicians, groups, and/or virtual groups who exceed the minimum case volume for each of the 10 MIPS cost measures.

Can the Denominator (Maximum Number of Points) be Lower than 100?

Yes, we will lower the denominator by 10 points for each measure for which you don't meet case minimum. For example, if you meet case minimum (and can therefore be scored) on 3 measures, your denominator will be 30 points.

How is my Cost Performance Category Percent Score Calculated?

The Cost performance category score is the equally-weighted average of all scored measures. For example, if only 1 measure can be scored, then that measure's score will serve as the performance category score. If only 4 out of 10 measures can be scored, then the maximum amount of points available (the denominator) will be 40.

Cost Performance Category Percent Score

=

Total Achievement Points Earned for Scored Measures

Total Available Measure Achievement Points*

*Total Available Measure Achievement Points = the number of scored measures x 10

Scoring Example

Let's continue our previous example of the small practice reporting as a group. They only met the case minimum for the TPCC measure.

When evaluated against the performance period benchmark, they earn 6.3 points out of 10 points for the measure.

Cost Performance Category Percent Score: **63%**

=

Total Achievement Points Earned for Scored Measures: 6.3

Total Available Measure Achievement Points: 10

Can the Cost Performance Category be Reweighted?

If you can’t be scored on any of the cost measures (you don’t meet case minimum for any of them, or we are unable to establish a benchmark for any of the measures for which you do meet the case minimum), you won’t be scored on this category and it will be reweighted to 0 percent of your final score.

We continue to apply our extreme and uncontrollable circumstance policy to all performance categories. Clinicians who qualify for the automatic extreme and uncontrollable circumstance policy, or who have an approved extreme and uncontrollable circumstance application that includes the Cost performance category will not be scored on Cost, regardless of whether we receive Medicare claims data for the clinician.

Please refer to Appendix B for more information on category reweighting, including the extreme and uncontrollable circumstances policy.

MIPS IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY

MIPS Improvement Activities Performance Category

Improvement Activities

15% of MIPS Score

What are the Data Submission Requirements for the Improvement Activities Performance Category?

You can earn up to 40 points in the Improvement Activities performance category by submitting between 1 and 4 improvement activities.

How are Activities Assessed and Scored?

Improvement activities have been assigned to one of two categories: medium-weighted or high-weighted. High-weighted activities earn twice as many points as medium-weighted activities.

Generally speaking, clinicians, groups, and virtual groups will receive the following points for their submitted activities:

Medium-weighted activities =
10 points

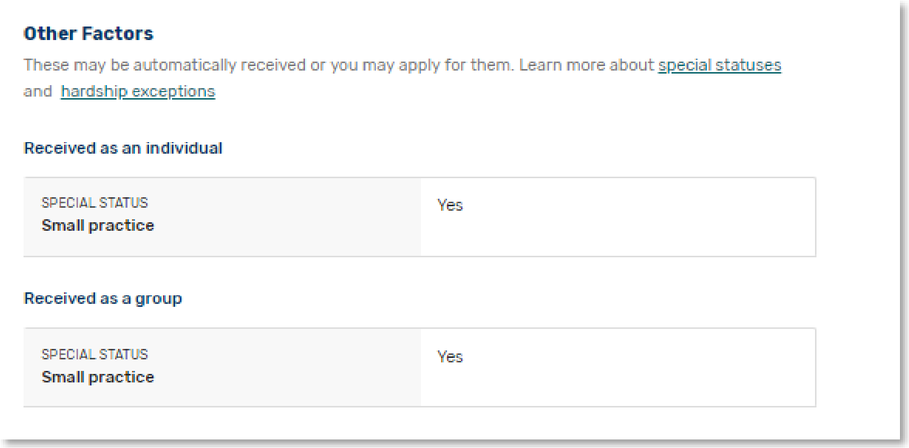
High-weighted activities =
20 points

To earn the maximum score of 40 points for the Improvement Activities performance category, you can pick any of these:

- 2 high-weighted activities
- 1 high-weighted activity and 2 medium-weighted activities
- 4 medium-weighted activities

How are Activities Assessed and Scored?

More points are given for improvement activities for clinicians, groups and virtual groups identified with a 1) small practice designation (15 or fewer NPIs), 2) non-patient facing designation, 3) health professional shortage area (HPSA) or 4) rural designation on the QPP Participation Status Tool.



Other Factors

These may be automatically received or you may apply for them. Learn more about special statuses and hardship exceptions

Received as an individual

SPECIAL STATUS **Small practice**	Yes

Received as a group

SPECIAL STATUS **Small practice**	Yes

Disclaimer: Whenever possible, we've incorporated images from the Performance Year 2018 QPP submission system to connect scoring policies with the submission experience. Keep in mind that these images may not exactly represent what you will see in the Performance Year 2019 QPP submission system.

These clinicians, groups, and virtual groups will receive the following points for their submitted activities:

Medium-weighted activities =
20 points

High-weighted activities =
40 points

To earn the maximum 40 points for the improvement activity performance category, they can complete either:

40 points = 2 medium-weighted activities OR 1 high-weighted activity

To learn more, see the MIPS Improvement Activities Fact Sheet or review the Improvement Activities Inventory.

How Many Points Can I Earn in the Improvement Activities Performance Category?

Clinicians, groups, and virtual groups can earn a maximum of 40 points in the Improvement Activities performance category. The Improvement Activities score, like all performance categories, is capped at 100 percent.

Can the Denominator (Maximum Number of Points) be Lower than 40?

No, you will always be scored out of 40 points in the Improvement Activities performance category, though you may receive more points per activity based on your circumstances.

How is My Improvement Activities Performance Category Percent Score Calculated?

The Improvement Activities performance category is 15 percent of your final score for the 2019 performance year.

$$\text{Improvement Activities Performance Category Percent Score} = \frac{\text{Total Points Earned for Completed Activities}}{\text{Total Possible Points (40)}}$$

The maximum score is 100 percent of the category weight.

Scoring Example

Let’s continue our previous example of the small practice reporting as a group. They cannot attest to having participated in CAHPS as an improvement activity because they did not meet beneficiary sampling requirements. They selected 2 improvement activities, 1 medium-weighted and 1 high-weighted. Because they are a small practice, they earn double points for each activity reported.

Improvement Activities Performance Category Percent Score:
100%

=

Total Points Earned for Completed Activities:
20 + 40

Total Possible Points: 40

Even if you submit additional activities, you cannot earn more than 100 percent in the performance category.

How Does Scoring Work if I'm in a Patient-centered Medical Home or an APM?

If you're in a certified or recognized patient-centered medical home, comparable specialty practice, or an APM designated as a Medical Home Model**,** you'll earn full credit for the Improvement Activities performance category by attesting to it during the submission period.

For 2019 group participation, at least 50 percent of all site locations under the TIN must meet this criterion in order for the entire TIN to qualify for the full credit.

For 2019 virtual group participation, at least 50 percent of all site locations across all the TINs in the virtual group must meet this criterion in order for the entire virtual group to qualify for the full credit.

In addition, if you are identified as an Alternate Payment Model (APM) participant but are NOT scored under the APM scoring standard, your improvement activities performance category score will be at least 50 percent based on your APM participation.

Can the Improvement Activities Performance Category be Reweighted?

We apply our extreme and uncontrollable circumstance policy to all of the performance categories. Please refer to Appendix B for more information on category reweighting, including the extreme and uncontrollable circumstances policy.

MIPS PROMOTING INTEROPERABILITY PERFORMANCE CATEGORY

What are the Data Submission Requirements for the Promoting Interoperability Performance Category?

Promoting Interoperability

25% of MIPS Score

We've overhauled our approach to this performance category, and moved away from the base, performance, and bonus measure requirements and scoring from previous performance years.

Beginning in 2019, there is a single set of measures and objectives to report. All measures are required as noted in the table below, unless you can claim an exclusion. When you report on required measures that have a numerator/denominator, you have to submit at least a 1 in the numerator if you do not claim an exclusion.

Objectives	Measures	Requirements
e-Prescribing	**e-Prescribing**	Required unless an exclusion is claimed
	Bonus (Optional): Query of Prescription Drug Monitoring Program (PDMP)	Optional measures cannot be reported if an exclusion is claimed for the required e-Prescribing measure
	Bonus (Optional): Verify Opioid Treatment Agreement	Optional measures cannot be reported if an exclusion is claimed for the required e-Prescribing measure
Health Information Exchange	**Support Electronic Referral Loops by Sending Health Information**	Required unless an exclusion is claimed
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	Required unless an exclusion is claimed
Provider to Patient Exchange	**Provide Patients Electronic Access to Their Health Information**	Required (no exclusion available)
Public Health and Clinical Data Exchange	**Report to two different public health agencies or clinical data registries for any of the following:** • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	Required unless an exclusion(s) is claimed

What are the Data Submission Requirements for the Promoting Interoperability Performance Category?

In addition to reporting the previously listed measures, you must also:

- Use 2015 Edition CEHRT to meet the measures above and collect your data (certified by the last day of the performance period)
- Submit a "yes" to the Prevention of Information Blocking attestation
- Submit a "yes" to the ONC Direct Review attestation
- Submit a "yes" that you have completed the Security Risk Analysis measure during 2019
- Submit the CMS Certification ID for your EHR product(s) as proof that it is certified by ONC to the 2015 Edition (you can find this information at https://chpl.healthit.gov/#/search)

If any of these requirements are not met, you will get 0 points in the Promoting Interoperability performance category.

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for Year 3 (2019)?

Beginning with the 2019 performance period, each required measure will be scored based on the performance you report. The measure performance rate is calculated based on the submitted numerator and denominator, except for the Public Health and Clinical Data Exchange objective's measures, which require a "yes" or "no" submission. Each measure will contribute to the clinician's total Promoting Interoperability performance category score.

NOTE: If exclusions are claimed, the points for excluded measures will be reallocated to other measures.

How are Measures Assessed and Scored in the Promoting Interoperability Performance Category for Year 3 (2019)?

Each required measure (or objective, in the case of the Public Health and Clinical Data Exchange) has a maximum number of points that can be earned based on performance.

For measures submitted with a numerator and denominator, we calculate a score for each measure by dividing the numerator by the denominator you submitted for the measure, and then multiplying that performance rate by the maximum points available for the measure.

- **Exception:** The 2 bonus measures in the e-Prescribing objective will earn 5 points each if submitted.
- **Exception:** When a clinician earns a measure score of less than 0.5, the score is rounded up to 1 as long as at the clinician reported on at least 1 patient.

Objectives	Measures	Maximum Points
e-Prescribing	**e-Prescribing**	10 points
	Bonus (optional): Query of Prescription Drug Monitoring Program (PDMP)	5 bonus points
	Bonus (optional): Verify Opioid Treatment Agreement	5 bonus points
Health Information Exchange	**Support Electronic Referral Loops by Sending Health Information**	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	**Provide Patients Electronic Access to Their Health Information**	40 points
Public Health and Clinical Data Exchange	**Report to two different public health agencies or clinical data registries for any of the following:** • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	10 points

Measure Scoring Example

A MIPS eligible clinician submits a numerator of 187 and a denominator of 220 for the Provide Patients Electronic Access to their Health Information measure (worth up to 40 points):

Performance Rate X Total Possible Measure Points = Points Awarded Towards Your Total Promoting Interoperability Performance Category Score

Provide Patients Electronic Access to Their Health Information Measure Example:

$$\frac{187}{220} \text{ Performance Rate} \quad 85\% \text{ Performance Rate} \times 40 = 34 \text{ Points}$$

34 Points Towards Your Total Promoting Interoperability Performance Score

The Public Health and Clinical Data Exchange objective is scored a bit differently because these measures are submitted with a “yes” or “no” instead of numerator and denominator values.

MIPS eligible clinicians will receive 10 points in this objective when:

- They submit a “yes” to 2 measures in the objective*
- They submit a “yes” to 1 measure and can claim an exclusion for a measure

*You can report the same measure twice as long as you’re actively engaged with two different agencies or registries.

How Many Points Can I Earn in the Promoting Interoperability Performance Category?

While there are 110 total points available, clinicians, groups, and virtual groups cannot earn more than 100 points in the Promoting Interoperability performance category. The Promoting Interoperability score, like all performance categories, is capped at 100 percent.

Can the Denominator (Maximum Number of Points) Be Lower than 100?

No, you will always be scored out of 100 points in the Promoting Interoperability performance category. If you qualify for and claim an exclusion(s), those points will be reallocated to another measure or objective instead of being removed from the denominator. Please see Appendix D for detailed information about how points are reallocated when an exclusion(s) is claimed.

How is the Promoting Interoperability Performance Category Scored?

We'll add the scores for each of the individual measures (or objective) together and divide the sum by the total possible achievement points (100 points) to calculate the Promoting Interoperability performance category percent score.

REMINDER: You will receive 0 points in the Promoting Interoperability performance category if you fail to submit a required attestation, report on a required measure or claim an exclusion for a required measure (where applicable).

$$\text{Promoting Interoperability Performance Category Percent Score} = \frac{\text{Total Points Earned for Completed Measures}}{\text{Total Possible Measure Points}}$$

Scoring Example

Let’s continue our example of the small practice participating as a group. While small practices can apply for a hardship exception, this group has EHR technology certified to the 2015 Edition, which they also used to submit eCQMs for the Quality category.

Measures	Numerator / Denominator (Performance Rate)	Maximum Points	Points Earned
e-Prescribing	Exclusion claimed	10 points → 0 points	N/A
Bonus (optional): Query of Prescription Drug Monitoring Program (PDMP)	Not reported	5 bonus points	N/A
Bonus (optional): Verify Opioid Treatment Agreement	Not reported	5 bonus points	N/A
Support Electronic Referral Loops by Sending Health Information	180 / 250 (.72)	20 points → 25 points re-allocated from e-Prescribing	.72 x 25 = 18 points
Support Electronic Referral Loops by Receiving and Incorporating Health Information	176 / 200 (.88)	20 points → 25 points re-allocated from e-Prescribing	.88 x 25 = 22
Provide Patients Electronic Access to Their Health Information	187 / 220 (.85)	40 points	.85 x 40 = 34 points
Report to 2 different public health agencies or clinical data registries for any of the following: • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	• Reported “yes” to Immunization Registry Reporting measure • Claimed exclusion for Clinical Data Registry Reporting measure	10 points	10 points (this objective is all or nothing)
Promoting Interoperability Performance Category Score			84 points / 100 points = 84%

Can the Promoting Interoperability Performance Category be Reweighted?

There are 2 ways the Promoting Interoperability performance category could be reweighted to 0 percent of your final score:

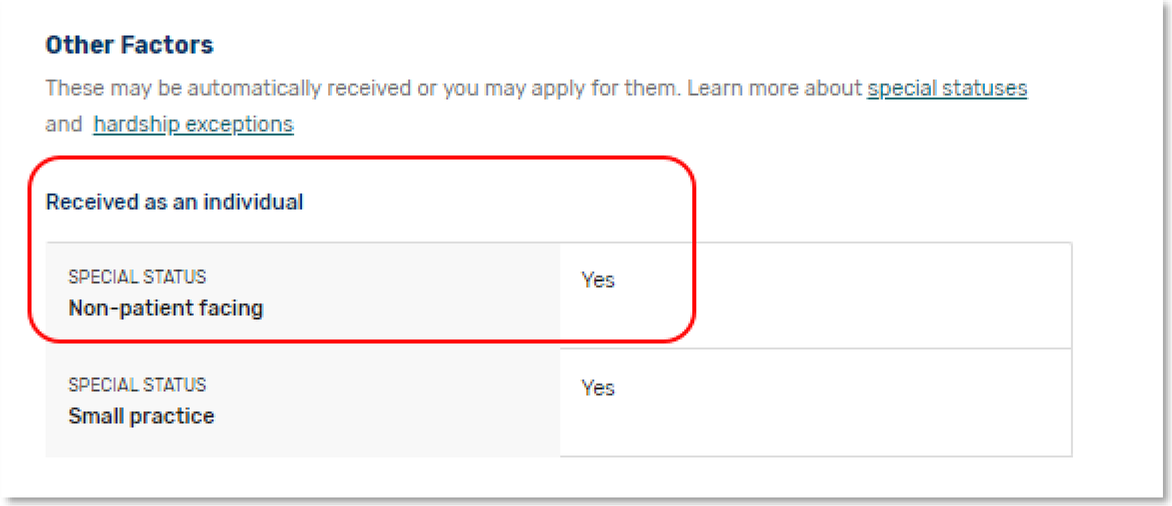
1. You submit a Promoting Interoperability Hardship Exception Application, citing one of the following specified reasons for review and approval:
   - Insufficient internet connectivity
   - Extreme and uncontrollable circumstances
   - Lack of control over the availability of CEHRT
   - Small Practice
   - Decertified EHR

If we approve your application, then the Promoting Interoperability performance category will be reweighted, unless you submit data for this performance category. Learn more about Hardship Exceptions.

2. You qualify for automatic reweighting. For 2019, you qualify for automatic reweighting if you qualify as any of the following (see the QPP Participation Status Tool):

- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist
- Hospital-based Clinician
- Ambulatory Surgical Center (ASC)-based Clinician
- Non-patient Facing Clinician
- NEW Physical Therapist
- NEW Occupational Therapist
- NEW Qualified Speech-language Pathologist
- NEW Qualified Audiologist
- NEW Clinical Psychologist
- NEW Registered Dietitian or Nutrition Professional

Can the Promoting Interoperability Performance Category be Reweighted?



Other Factors

These may be automatically received or you may apply for them. Learn more about special statuses and hardship exceptions

Received as an individual

SPECIAL STATUS **Non-patient facing**	Yes
SPECIAL STATUS **Small practice**	Yes

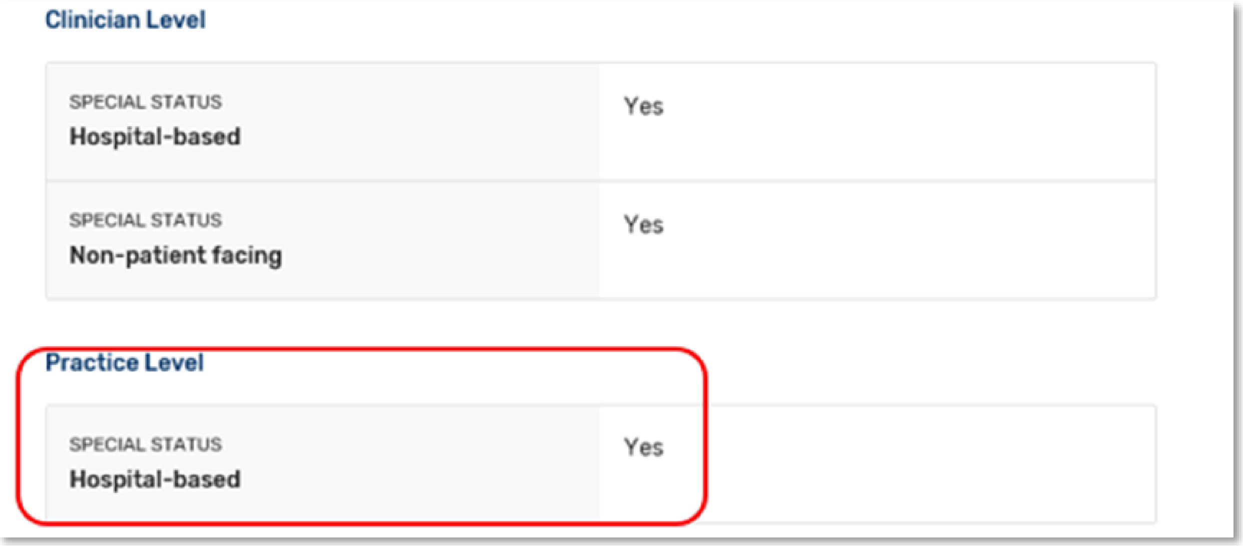
Disclaimer: Whenever possible, we've incorporated images from the Performance Year 2018 QPP submission system to connect scoring policies with the submission experience. Keep in mind that these images may not exactly represent what you will see in the Performance Year 2019 QPP submission system.

NOTE: If you have an approved exception or qualify for automatic reweighting, we'll **reweight the category to 0 percent and redistribute the 25 percent weight usually to the Quality performance category** so you can earn up to 100 points in your MIPS final score. However, you can still report if you want to. If you submit data on the measures for the Promoting Interoperability performance category either as an individual, a group, or virtual group, then we'll score your performance just like any other clinician in MIPS and weight your Promoting Interoperability performance category at 25 percent of the final score.

How Does Reweighting Work If We're Participating as a Group or Virtual Group?

A group or virtual group's Promoting Interoperability performance category score will be reweighted when:

- The group or virtual group has an approved hardship exception or qualifies for automatic reweighting
- All of the MIPS eligible clinicians in the group or virtual group individually qualify for reweighting



Clinician Level

SPECIAL STATUS **Hospital-based**	Yes
SPECIAL STATUS **Non-patient facing**	Yes

Practice Level

SPECIAL STATUS **Hospital-based**	Yes

Disclaimer: Whenever possible, we've incorporated images from the Performance Year 2018 QPP submission system to connect scoring policies with the submission experience. Keep in mind that these images may not exactly represent what you will see in the Performance Year 2019 QPP submission system.

If 100 percent of the MIPS eligible clinicians within a group do not qualify for an automatic reweighting or do not submit an application for and receive a hardship exception, then the group will not qualify for reweighting and will have to submit data for the Promoting Interoperability performance category. Just as with individual participation, groups and virtual groups who qualify for reweighting but submit data for this performance category will be scored just like any other clinician in MIPS, and their Promoting Interoperability performance category will be weighted at 25 percent of the final score.

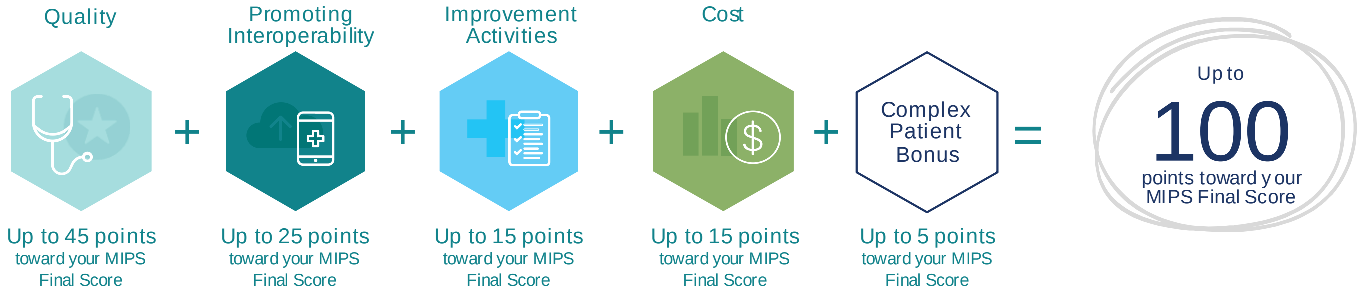
NOTE: CMS has proposed a clarification to the non-patient facing policy; if finalized, a group that is identified as non-patient facing would qualify for automatic reweighting.

MIPS FINAL SCORE

How is My Final Score Calculated?

We multiply your performance category score by the category's weight, and multiple that by 100, to determine the number of points that contribute to your final score for each performance category. Then we add the points for each performance category to any complex patient bonus you may have received to arrive at your final score.

2019 MIPS Performance Category Weights



Quality: Up to 45 points toward your MIPS Final Score

+

Promoting Interoperability: Up to 25 points toward your MIPS Final Score

+

Improvement Activities: Up to 15 points toward your MIPS Final Score

+

Cost: Up to 15 points toward your MIPS Final Score

+

Complex Patient Bonus: Up to 5 points toward your MIPS Final Score

=

Up to 100 points toward your MIPS Final Score

What is the Complex Patient Bonus?

The Complex Patient Bonus is added to the MIPS final score and based on the overall medical complexity and social risk for the patients treated by a clinician or group. We recognize that there can be challenges and additional costs associated with the care you provide to these patients.

When determining bonus points for your care of complex patients, we look at two indicators:

- The medical complexity of your Medicare patients as measured through average Hierarchical Condition Category (HCC) risk scores, and
- Social risk identified for your patients as measured through the proportion of patients with dual eligible status (qualified to receive both Medicare and Medicaid benefits).

What is the Complex Patient Bonus?

All MIPS eligible clinicians, groups, virtual groups, and APM Entities who submit data in at least one performance category can expect to receive a complex patient bonus, ranging from 0 to 5 points. Projections for the 2018 performance period were that clinicians in the lowest quartile (based on HCC risk scores) would receive a bonus of about 2.5 points, and clinicians in the highest quartile would receive about 3.7 points (based on historical data).

For more information on this bonus, please refer to the 2019 Complex Patient Bonus Fact Sheet.

Scoring Example

Let’s continue our example of the small practice reporting as a group and review how the final score is calculated.

Quality		Cost		Improvement Activities		Promoting Interoperability		Complex Patient Bonus		
95.8% X 45% X 100 =		63% X 15% X 100 =		100% X 15% X 100 =		84% X 25% X 100 =				
43.11 points	+	**9.45 points**	+	**15.00 points**	+	**21.00 points**	+	**3.20 points**	=	91.76 **points**
toward the Final Score		toward the Final Score		toward the Final Score		toward the Final Score		toward the Final Score		

The MIPS final score cannot exceed 100 points.

PAYMENT ADJUSTMENT BASED ON MIPS FINAL SCORE

How Does My MIPS Final Score Determine My Payment Adjustment?

The MIPS final score will be between 0 and 100 points. Each final score will correlate to a payment adjustment(s), but in most cases we can't project what this correlation will be. Why? MIPS is required by law to be a budget neutral program, which generally means that the amount of the payment adjustments will be dependent on the overall performance of clinicians in the program.

Final Score	Payment Adjustment
75.00 – 100.00 points (Additional performance threshold = 75.00 points)	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Eligible for additional adjustment for exceptional performance (subject to a scaling factor to account for available funds)
30.01 – 74.99 points	• Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality) • Not eligible for additional adjustment for exceptional performance
30.00 points (Performance threshold = 30.00 points)	• Neutral MIPS payment adjustment (0%)
7.51 – 29.99	• Negative MIPS payment adjustment greater than -7% and less than 0%
0 – 7.50 points	• Negative MIPS payment adjustment of -7%

Payment Adjustment Based on MIPS Final Score

How Does My MIPS Final Score Determine My Payment Adjustment?

There are two components of the MIPS payment adjustments. The first applies to all MIPS eligible clinicians, and the second is an additional payment adjustment for exceptional performance that applies only to those MIPS eligible clinicians with a final score of 75 points or higher.

- **MIPS Payment Adjustment** – The first component is calculated in a way to ensure budget neutrality. Clinicians with a final score at the performance threshold of 30 points earn a neutral adjustment. Clinicians with a final score above the performance threshold of 30 points earn a positive adjustment (subject to a scaling factor). Clinicians with a final score below the performance threshold of 30 points will be subject to a negative adjustment. The maximum negative adjustment is -7 percent. The final MIPS payment adjustments will be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold. More MIPS eligible clinicians with final scores above the performance threshold means the scaling factors would decrease because more MIPS eligible clinicians receive a positive MIPS payment adjustment. More MIPS eligible clinicians with final scores below the performance threshold means the scaling factors would increase because more MIPS eligible clinicians would have negative MIPS payment adjustments and relatively fewer MIPS eligible clinicians would receive positive MIPS payment adjustments.

- **Additional MIPS payment adjustment for exceptional performance** – The second component is applied to MIPS eligible clinicians with a final score of 75 points or higher. The amount of the adjustment is also applied on a linear scale so that clinicians with higher scores receive a higher adjustment. The amount of the adjustment is scaled; it will depend on the scores and the number of clinicians receiving a score of 75 points or higher.

RESOURCES, GLOSSARY, AND VERSION HISTORY

Resources, Glossary, and Version History

Resources

The following resources are or will be available on the QPP Resource Library.

General:

- 2019 Group Participation Guide
- 2019 Complex Patient Bonus Fact Sheet

Quality:

- 2019 Quality Benchmarks
- Medicare Shared Savings Program (2018 and 2019) Quality Benchmarks
- 2019 Quality Performance Category Fact Sheet
- 2019 MIPS Quality User Guide
- 2019 CMS Web Interface Fact Sheet
- 2019 CAHPS for MIPS Overview Fact Sheet
- Medicare Part B Claims Measure Specifications
- MIPS Clinical Quality Measure Specifications
- QCDR Measure Specifications
- CMS Web Interface Measure Specifications

Cost:

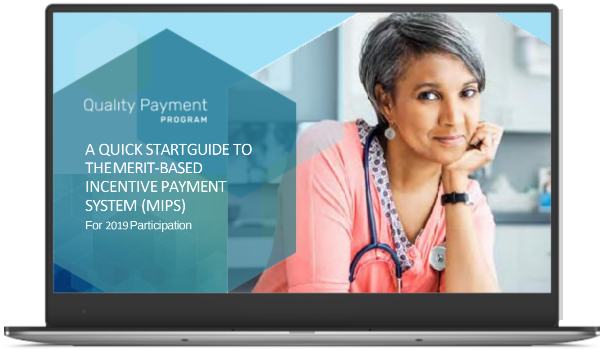
- 2019 Cost Performance Category Fact Sheet
- 2019 MIPS Cost User Guide
- 2019 Cost Measure Information Forms (specifications)

Improvement Activities:

- 2019 Improvement Activities Performance Category Fact Sheet
- 2019 Improvement Activities Inventory

Promoting Interoperability:

- 2019 Promoting Interoperability Performance Category Fact Sheet
- 2019 Promoting Interoperability Measure Specifications



Quality Payment
PROGRAM

A QUICK STARTGUIDE TO
THEMERIT-BASED
INCENTIVE PAYMENT
SYSTEM (MIPS)
For 2019 Participation

Resources, Glossary, and Version History

Glossary

ACO	Accountable Care Organization
APM	Alternative Payment Models
CAHPS	Consumer Assessment for Healthcare Plans and Systems
CEHRT	Certified Electronic Health Record Technology
CMS	Centers for Medicare & Medicaid Services
EHR	Electronic Health Record
MIPS	Merit-based Incentive Payment System
MSPB	Medicare Spending Per Beneficiary
NPI	National Provider Identifier
OCM	Oncology Care Model
PQRS	Physician Quality Reporting System
QCDR	Qualified Clinical Data Registry
QP	Qualifying APM Participant
TIN	Taxpayer Identification Number
VM	Value-Based Payment Modifier

Version History

Date	Description
1/23/2020	On page 48, revised language to remove italicized text below since the Query of PDMP measure now requires a Yes/No response instead of a numerator/denominator, per policies finalized in CY 2020 Final Rule for the 2019 performance period: **Exception:** The 2 bonus measures in the e-Prescribing objective will earn 5 points each if submitted*, regardless of performance. Measure scores are generally rounded to the nearest whole number*.
8/1/2019	Original version

APPENDICES

Appendix A: Scoring Quality Measures

This example can help you find a benchmark, figure achievement points, and pick the top 6 measures based on the number of points.

1. Find the benchmark and figure achievement points based on collection type for the measure.

- Achievement points are figured by mapping the performance rate to the benchmark for the measure, specific to collection type.
- **Example:** Small practice reporting as a group submits Measure 130 as an eCQM.

Measure Reported	Type of Measure	Collection Type	Measure Performance Rate	Cases Reported
Measure 130 – Documentation of current medications in the medical record	Process	eCQM	96.74 (mapped to highlighted decile below)	90

- This is an extract from the 2019 benchmarking file showing the range of performance rates associated with each decile for each collection type:

Measure Name	Measure ID #	Collection Type	Measure Type	Benchmark	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Documentation of current medications in the medical record	130	Medicare Part B Claims	Process	Y	97.95 - 99.51	99.52 - 99.91	99.92 - 99.99	--	--	--	--	100
Documentation of current medications in the medical record	130	eCQM	Process	Y	87.55 - 93.48	93.49 - 96.28	96.29 - 97.98	97.99 - 98.99	99.00 - 99.57	99.58 - 99.88	99.89 - 99.99	100
Documentation of current medications in the medical record	130	MIPS CQM	Process	Y	68.06 - 90.27	90.28 - 97.23	97.24 - 99.50	99.51 - 99.99	--	--	--	100

Appendix A: Scoring Quality Measures

2. Figure achievement points in a decile.

a. Determine the decile that the performance rate falls in:

Measure performance rate = 96.74

Measure Name	Documentation of current medications in the medical record
Measure ID#	130
Collection Type	eCQM
Measure Type	Process
Benchmark	Y
Decile 3	87.55 – 93.48
Decile 4	93.49 – 96.28
Decile 5	96.29 – 97.98
Decile 6	97.99 – 98.99
Decile 7	99.00 – 99.57
Decile 8	99.58 – 99.88
Decile 9	99.89 – 99.99
Decile 10	100

b. Apply the following formula based on the measure performance and decile range:

$$\underset{\text{decile \#}}{X} + \frac{\left[\underset{\text{performance rate}}{q} - \underset{\text{bottom of decile range}}{a}\right]}{\left[\underset{\text{top of decile range}}{b} - \underset{\text{bottom of decile range}}{a}\right]} = \text{Achievement Points}$$

NOTE: Partial achievement points are rounded to the tenths digit for partial points between 0.01 to 0.89. Partial achievement points above 0.9 are truncated to 0.9.

$$\underset{\text{decile \#}}{5} + \underbrace{\frac{\left[96.74 - 96.29\right]}{\left[97.98 - 96.29\right]}}_{= 0.26627} = 5.3$$

…which is rounded to 0.3

Appendix A: Scoring Quality Measures

3. Repeat assignment of achievement points for each submitted measure.

- **Example:** Small group submits 7 eCQMs and 2 claims measures, meeting data completeness for all measures.

Measures Reported	Collection Type	Types of Measure	Measure Performance Rate	Cases Reported	Achievement Points	Comments
Measure 130 documentation of current medications in the medical record	eCQM	Process	96.74	90	5.3	Compare to benchmark; meets end-to-end bonus point criteria
Measure 111 pneumococcal vaccination for elderly	eCQM	Process	22.12	112	3.3	Compare to benchmark; meets end-to-end bonus point criteria
Measure 111 pneumococcal vaccination for elderly	Medicare Part B Claims	Process	70.56	113	5.1	Compare to benchmark
Measure 113 colorectal cancer screening	eCQM	Process	36.32	13	3.0	Apply 3-point floor because it's below 20 case minimum; meets end-to-end bonus point criteria
Measure 119 diabetes: attention for nephropathy	eCQM	Process	77.19	43	4.5	Compare to benchmark; meets end-to-end bonus point criteria
Measure 110 preventive care and screening: influenza immunization	eCQM	Process	14.3	32	3.0	Compare to benchmark; apply 3-point floor due to poor performance; meets end-to-end bonus point criteria
Measure 236 controlling high blood pressure	eCQM	Outcome	63.82	86	5.8	Compare to benchmark; meets end-to-end bonus point criteria
Measure 238 use of high-risk meds in elderly	eCQM	Process*	2.01	40	5.5	Compare to benchmark; meets end-to-end bonus point criteria
Measure 317 preventive care—high blood pressure	Medicare Part B Claims	Process	35.81	160	3.1	Compare to benchmark

*This is an inverted measure.

Appendix A: Scoring Quality Measures

4. Sort and group measures based on achievement and bonus points.

a. First identify the highest scoring outcome measure based on achievement points, then identify the next 5 highest scoring measures based on achievement points.

The following measures contribute achievement points AND bonus points toward the Quality performance category score.

Measures Sorted by Performance	Collection Type	Performance Rate	Achievement Points	Bonus Points
1. Outcome/High-priority: **Measure 236**	eCQM	63.82	5.8	1
2. **Measure 238**	eCQM	2.01	5.5	1
3. **Measure 130**	eCQM	96.74	5.3	1
4. **Measure 111**	Medicare Part B Claims	70.56	5.1	N/A
5. **Measure 119**	eCQM	77.19	4.5	1
6. **Measure 317**	Medicare Part B Claims	35.81	3.1	N/A

b. Identify measures that contribute bonus points only to the Quality performance category score.

The following measures do not contribute achievement points but DO contribute bonus points toward the Quality performance category score.

Measures Sorted by Performance	Collection Type	Performance Rate	Achievement Points	Bonus Points	Comment
Measure 111	eCQM	70.56	~~3.3~~	1	Higher scoring than Measure 317 but Measure 111 is already included in the top 6 as a claims measure
Measure 110	eCQM	14.3	~~3.0~~	1	Not one of the top 6 scored measures

c. Identify measures that won't contribute any points to the Quality performance category score.

The following measure does not contribute achievement points or bonus points toward the Quality performance category score.

Measures Sorted by Performance	Collection Type	Performance Rate	Achievement Points	Bonus Points	Comment
Measure 113	eCQM	36.32	~~3.0~~	~~1~~	• Not one of the top 6 scored measures • Group has already reached the 10% cap on the end-to-end bonus points.

Appendix B: Reweighting the Performance Categories

Extreme and Uncontrollable Circumstances

An extreme and uncontrollable circumstance is defined as a rare event (i.e. natural disaster or other extraordinary circumstance) that is entirely outside the control of the clinician and/or of the facility and that affects the MIPS eligible clinician's ability to collect and submit information used to generate a performance score for an extended period. Under the Extreme and Uncontrollable Circumstances Policy, we aimed to reduce the burden on MIPS eligible clinicians who have been affected by extreme circumstances beyond their control.

If you experienced an extreme and uncontrollable circumstance that affected the 2019 performance year, you may qualify for performance category reweighting either through our automatic policy or by completing the Extreme and Uncontrollable Circumstances Application.

Appendix B: Reweighting the Performance Categories

Performance Category Weight Redistribution

The table below outlines the performance category weights when 0, 1, or 2 performance categories are reweighted to 0 percent based on any circumstances described throughout this guide, including the Extreme and Uncontrollable Circumstances policy.

Performance Category Redistribution for the 2021 MIPS Payment Year

Reweighting Scenario	Quality	Cost	Improvement Activities (IA)	Promoting Interoperability (PI)
No Reweighting Needed				
General weighting for all 4 performance categories	45%	15%	15%	25%
Reweighting 1 Performance Category				
No Cost: *Cost → Quality*	60%	0%	15%	25%
No Promoting Interoperability: *PI → Quality*	70%	15%	15%	0%
No Quality: *Quality → IA and PI*	0%	15%	40%	45%
No Improvement Activities: *IA → Quality*	60%	15%	0%	25%
Reweighting 2 Performance Categories				
No Cost and no Promoting Interoperability *Cost and PI → Quality*	85%	0%	15%	0%
No Cost and no Quality *Cost and Quality → IA and PI*	0%	0%	50%	50%
No Cost and no Improvement Activities *Cost and IA → Quality*	75%	0%	0%	25%
No Promoting Interoperability and no Quality *PI and Quality → IA*	0%	15%	85%	0%
No Promoting Interoperability and no Improvement Activities *PI and IA → Quality*	85%	15%	0%	0%
No Quality and no Improvement Activities *Quality and IA → PI*	0%	15%	0%	85%

NOTE: If you have multiple performance categories reweighted to 0 percent so that a single performance category is weighted as 100 percent of your final score, you will receive a score equal to the performance threshold regardless of any data submitted or not submitted.

Appendix C: End-to-End Electronic Reporting (eCQMs and MIPS CQMs)

The table below outlines the submission options for submitting eCQMs or MIPS CQMs that meet the criteria to earn end-to-end electronic reporting bonus points.

Collection Type	Submission Type	Format/Specification	Specification Indicators	Benchmark
eCQM	Login and Upload	QRDA III	N/A	eCQM
eCQM	Direct Login and Upload	QPP JSON	‘submissionMethod=electronicHealthRecord’	eCQM
MIPS CQM (no eCQM equivalent)*	Direct Login and Upload	QPP JSON	‘submissionMethod=registry’ ‘isendtoendreported=true’	MIPS CQM

*If you submit a MIPS CQM with an eCQM equivalent, your submission will be rejected if it includes an indicator of end-to-end electronic reporting.

If you are reporting a mixture of eCQMs and MIPS CQMs using the QPP JSON format, you must submit these types as separate measurement sets:

- One measurement set of eCQMs (indicate EHR as the submission method) and a separate measurement set of MIPS CQMs (indicate Registry as the submission method).

Please refer to the Submission API documentation in the Developer Tools section of the QPP website for the most current information.

Appendix D: Reallocation of Points for Promoting Interoperability Measure(s) When an Exclusion is Claimed

The table below outlines where points are redistributed when an exclusion is claimed.

Objectives	Measures	Exclusion Available	When the Exclusion is Claimed…
e-Prescribing	e-Prescribing	Yes	…the 10 points are redistributed equally among the measures associated with the Health Information Exchange objective: • 5 points to the Support Electronic Referral Loops by Sending Health Information measure • 5 points to the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure
	Bonus (optional): Query of Prescription Drug Monitoring Program (PDMP)	N/A	N/A
	Bonus (optional): Verify Opioid Treatment Agreement	N/A	N/A
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	Yes	…the 20 points are redistributed to the Provide Patients Electronic Access to the Health Information **(proposed in the CY 2020 NPRM)**
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	Yes	…the 20 points are redistributed to the Support Electronic Referral Loops by Sending Health Information measure
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	No	N/A
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	Yes	…the 10 points are still available in this objective if you **claim one exclusion** and submit a 'yes' attestation for one of the 5 measures in the objective. …the 10 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure if you **claim two exclusions**.