MIPS Program: 2019 Quality Performance Category

The 2019 Medicare Physician Fee Schedule final rule includes provisions for the 2019 Quality Payment Program (QPP), which impacts 2021 payment. The QPP includes both the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Following the MACRA technical corrections enacted in early 2018, CMS is continuing the MIPS transition period by setting the MIPS performance threshold at a level other than the mean or median of the previous year’s scores and keeping the Cost category weight below 30% of the final MIPS score.

CMS set the 2019 MIPS final score threshold at 30 points, up from 15 points in 2018. To avoid the 7% penalty in 2021, physicians must earn at least 30 MIPS points through their 2019 performance.

This guide is developed for ASCRS•ASOA members to familiarize themselves with the full requirements of the Quality category, and to assist them in choosing the best participation option for their practice. ASCRS also has developed guides on the other three categories of MIPS. In addition, ASCRS•ASOA has developed a guide on Advanced APMs and MIPS APMs. Physicians participating in MIPS APMs, such as Medicare Shared Savings Track 1 ACOs, should consult that guide for details regarding their scoring under the MIPS program.

Quality Category Weight – 45%

For 2019, CMS will weight a provider’s Quality performance score at 45% of the overall MIPS final score. Prior to passage of technical corrections to the MACRA statute, CMS was required to increase Cost category weight to 30% in 2019, to impact 2021 payments. The Quality category weight was scheduled to decrease to 30% in 2019. However, now CMS has the authority to keep the Cost category weight below 30% for three additional years and set it at 15% for 2019. If a physician or group does not have any cost measures attributed, the weight of the Cost category is transferred to Quality. The MACRA statute requires the Quality category weight to be no lower than 30%.

In some cases, CMS may determine that a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider’s quality performance score to make up the difference.

Quality Category Performance Period

In 2019, physicians and groups must submit quality measure data for the full calendar year to be considered full participants in the MIPS program.

Quality Reporting Requirements

To achieve full credit for the Quality performance category, physicians must achieve a total of 60 or 70 points, depending on practice size. Practices of 15 or fewer providers must report 6 measures, each worth up to 10 total possible points, while practices of 16 or more providers will also be scored on a claims-based hospital re-admission measure in addition to the 6 reported measures, each worth up to 10 possible points. Physicians must report on 60% of all patients, if reporting via registry or EHR, and 60% of all Medicare Part B patients if reporting via claims.

Physicians must report a minimum of 6 measures, with at least one being an outcome measure, if available. If no outcome measure applies to the clinician, he or she would report one “high priority” measure. High priority measures are certain CMS designated measures that include all outcome measures.
For the 2019 performance period, only practices of 15 or fewer Medicare eligible clinicians may submit quality measures through claims.

Each measure reported must have a minimum of 20 cases to be included in the Quality category score.

In addition, CMS intends to publish a list of non-MIPS measures, owned by Qualified Clinical Data Registries (QCDRs), such as the IRIS Registry, that can be reported through such QCDRs for credit under MIPS. The non-MIPS measure list is expected to be released in early 2019.

In 2019, CMS will continue to measure a physician’s improvement on quality measures prior to the previous year. Physicians have the opportunity to earn up to 10 additional points, not to exceed the 60 or 70 total available points in the category, from year-to-year improvement in the Quality category.

Topped Out Measures

After determining that several ophthalmology measures—predominantly those reported via claims—have been “topped out” for multiple years—meaning that overall performance is consistently high—CMS is capping the total possible points for these measures at seven points in 2019, instead of the usual ten possible points per measure. Therefore, if a physician or group reports only capped measures, they cannot earn the full available points for the category. Under CMS’ topped out measure methodology, it is likely that these measures will be removed from the MIPS program for the 2020 performance period. This impacts nearly all ophthalmology measures, as well as many for other specialties, reported via claims and some reported via registry and EHR. A full list is included in the Quality Measures and Benchmarks Guide.

ASCRS and the medical community have consistently opposed the topped out measure methodology and argued that physicians should continue to receive full credit for maintaining high quality. We will continue to work with the medical community to address this issue.

Multiple Submission Methods

For 2019, CMS is instituting a new option that allows physicians to submit measures through multiple submission types. Physicians and groups will be able to select any six measures and submit them through a variety of options. For example, a physician may report four measures through claims, but meet the full required six by submitting two more through registry. In addition, for measures that have multiple submission options, the physician or group may submit through both mechanisms and CMS will include whichever one has the highest score in the final category score. If physicians or groups do not have enough measures available through a particular submission type, they are not required to add a new submission mechanism to make up the full six measures.

Transition Period Scoring Consideration

As CMS is continuing its transition policies in 2019, it will maintain a measure score “floor” of three points for small practices of 15 or fewer eligible clinicians. For larger practices of 16 or more eligible clinicians, CMS has set a one-point measure floor. If providers report a particular measure, but do not meet the benchmarks or submission thresholds, they will automatically receive a score of three points for that measure if they are in a small practice, and one point if they are in a larger practice.

Quality Achievement Score

Under MIPS, providers must demonstrate achievement on a quality measure, relative to a benchmark performance. For the 2019 performance year, CMS will set a baseline performance benchmark for each measure based on historical performance data. A physician’s benchmark score on each measure is known as the “achievement” score. The achievement score will be added to any improvement or bonus points to determine the category score.

For 2019, each measure has specific benchmarks depending on submission method (i.e., claims, EHR, registry) that are scored on a decile, or 10-point, scale. For each submission method, CMS has assigned different levels of performance to each decile.
Each decile is a range of performance levels for the measure that correspond to points earned for the measure. For example, if a physician submits data showing 83% performance on a measure, and the 5th decile begins at 72% performance and the 6th decile begins at 85% performance, then he or she will receive between 5 and 5.9 points because 83% is in the 5th decile. If a physician or group has submitted a measure through multiple submission mechanisms, CMS will use whichever score is highest toward the achievement score.

The total possible achievement score in the Quality category depends on the size of the practice:

- Providers in groups of 15 or fewer eligible clinicians are subject to 6 measures and are eligible to receive up to **60 points** in the Quality performance category.
- Providers in groups of 16 or more are subject to 7 measures (6 to be reported, and the hospital re-admission measure if 200 patients are attributed) and are eligible to receive up to **70 points** in the Quality performance category. If 200 patients are not attributed, the hospital re-admission measure will not be calculated, and providers will only be scored on the reported 6 measures, for a total possible score of 60 points.

### Quality Improvement Score

For 2019 performance, CMS will also calculate a physician’s or group’s quality improvement score. Because physicians have the option of choosing which quality measures to report, and may not report the same measures from year to year, CMS is evaluating improvement on a category basis.

CMS will compare a physician’s total 2018 achievement score, which is determined based on the physician’s performance relative to the benchmarks and excludes any bonus points, and compare it to the 2019 achievement score. CMS will award between 1 and 10 percentage points, up to the total 60 or 70 available for the category, depending on how much a physician’s or group’s achievement score improved above the prior year.

The improvement score is derived by:

- The increase in quality achievement percent score from prior performance period to current performance period
- Divided by prior performance period quality achievement percent score
- Multiplied by 10%

Improvement scores cannot be less than zero points, and thus a physician who earns a lower achievement score in the current performance period than the prior one will not be penalized.

Due to the flexibility policies CMS offered to avoid a penalty by submitting minimal data, for 2018 performance, physician or groups would only receive an improvement score if they participated in the Quality category fully in 2017. CMS will continue that policy for 2019 and only calculate improvement scores for physicians and groups who participated fully in 2018 and earned at least 30% of available points in the Quality category.

### Bonus Points

To incentivize providers to report on additional “high priority” measures, CMS will award bonus points to providers who report these measures. Specifically, CMS will award:

- Two bonus points for each additional outcome measure reported beyond the required one, or
- One bonus point for each additional high priority measure.

Bonus points for reporting additional high priority and outcome measures are capped at 10% of the total available points in the Quality performance category for providers. For example, if a provider is in a small practice and can score up to 60 points, the total bonus points that can be awarded is 6. **Bonus points will be awarded to applicable measures, even if the provider fails to meet the case minimum or data submission thresholds.** For example, if a physician reports an additional outcome measure, but fails to reach the 20-patient case minimum, he or she would receive the initial minimum “floor” score of 3
achievement points for the measure, then be awarded 2 more bonus points, resulting in a total score of 5 for the individual measure.

**Quality measures reported through “end-to-end” electronic submissions will earn the provider bonus points.** Providers may earn up to 10% of the total available points in the Quality performance category if they submit measures through EHR or a qualified clinical data registry that meet the definition of “end-to-end” electronic reporting. To be considered “end-to-end” electronic reporting, an automated process must be used to aggregate the measure data, calculate measure, perform any filtering of measurement data, and submit the data electronically to CMS. Systems that require manual abstraction and re-entry of data are not considered end-to-end and, therefore, not eligible for a bonus.

Each measure submitted electronically through EHR or qualified data registry will receive one bonus point. For example, if a provider is scored on 60 possible points in the Quality performance category, he or she can earn up to 6 bonus points for electronic submission toward the Quality category score. Electronic bonus points are awarded in addition to bonus points for additional high priority and outcome measures.

If a physician or group reports the same measure through multiple submission types and would be awarded bonus points for that measure through one of the submission mechanisms, the bonus points would still be added to the score even if the measure’s highest achievement score is for a mechanism that does not include a bonus. For example, a physician may submit a measure through the EHR, which would result in a one-point bonus for end-to-end reporting. However, if he or she submitted the same measure through claims and, based on the benchmarks, would score more achievement points, CMS would take the claims measure’s achievement points and still add the electronic end-to-end bonus.

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**Small Practice Bonus**

For 2019, CMS has moved the small practice bonus to the Quality category. In 2018, CMS added 5 points to the final MIPS score of any small group of 15 or fewer Medicare-eligible clinicians. For 2019, 6 bonus points will be added to the Quality category score of any small practice. Similar to the other bonuses discussed above, small practice bonus points will only be awarded up to the total 60 points available for the category.

**Quality Performance Score**

A provider’s Quality performance category score will be the sum of the achievement, improvement, and bonus points divided by the total available points, depending on practice size. The Quality category score will then be weighted to count for 50% of the total MIPS score.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Achievement Score</th>
<th>Bonus Points (high priority/outcome measures)</th>
<th>Bonus Points (electronic reporting)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure A submitted via claims</td>
<td>8</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Measure A submitted via EHR</td>
<td>4 (not included in category score since claims submission was higher)</td>
<td>1 (bonus still counts even though claims score was higher)</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Measure B submitted via EHR</td>
<td>6</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Measure C (first outcome) submitted via EHR</td>
<td>5</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Measure D (additional outcome) submitted via EHR</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Measure E (high priority) submitted via EHR</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Measure F submitted via EHR</td>
<td>7</td>
<td></td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>2019 Achievement Score (2018 Achievement Score of 30)</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----</td>
<td></td>
<td></td>
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<tr>
<td>Small Practice Bonus</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Quality Achievement and Bonus Points (of a possible 60)</td>
<td>55 (or 91.67%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Score</td>
<td>1.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Score</td>
<td>92.67% (will be weighted 45% of MIPS score; equals 41.67 final MIPS points)</td>
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</tbody>
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**Global and Population Measures**

Through administrative claims, CMS will assess physicians in practices of 16 or more eligible clinicians on an all-cause hospital re-admission measure, previously used to calculate the Value-Based Payment Modifier (VBPM).

CMS will attribute patients to this measure through the same flawed VBPM two-step attribution process, based on which provider bills the plurality of E/M codes during the performance period. ASCRS continues to oppose this attribution methodology and will continue to advocate in our comments on the final rule and in the future that CMS develop more appropriate attribution methodologies that do not hold physicians accountable for the cost of care they did not provide.

**Physicians do not need to report on these measures; CMS will score them based on administrative claims.**

**Data Submission**

Physicians and groups may report their quality performance data through claims, registry, EHR, or Web Interface (formerly known as GPRO—and only available for groups of 25 or more).

Physicians or groups do not need to use the same submission mechanism for every category.

**Additional Resources**

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.