The Physicians Advocacy Institute’s
Medicare Quality Payment Program (QPP)
Physician Education Initiative

2019 Quality Category Overview
2019 Quality Category Overview

2019 is the third year of the MACRA Quality Payment Program (QPP), under which physicians may choose to participate in an Advanced Alternative Payment Model (APM) or submit data to the Merit-Based Incentive Payment System (MIPS).

MIPS consolidates and sunsets the previous quality reporting programs by the Centers for Medicare and Medicaid Services (CMS), including the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Electronic Health Records (EHR) Incentive program (Meaningful Use), into one program. In 2019, MIPS has four weighted performance categories: quality (45%), based on PQRS; cost (15%), based on VM; promoting interoperability (PI) (25%), previously advancing care information (ACI); and improvement activities (15%).

This resource provides guidance for the quality category for individual and small group practices. Because the quality category is weighted at 45% of the 2019 MIPS final score, it is recommended that physicians carefully review all reporting requirements and weigh all options.

1 This resource focuses on the quality category reporting options for individual and small group practice reporting and does not address reporting requirements and scoring details for the CMS Web Interface reporting mechanism, which applies only to groups of 25 or more eligible clinicians. For details about the CMS Web Interface, visit CMS’s QPP Resource Library.
What are my options for the quality category?

Like 2018, the 2019 MIPS quality category has a full-year performance period ranging from January 1, 2019 – December 31, 2019. Physicians may choose to report data on quality measures at the individual, group, or Virtual Group level.

Starting in 2019, physicians, groups, and Virtual Groups may use multiple reporting mechanisms. If the same measures are submitted through multiple mechanisms, CMS will select the option with the greatest performance points for scoring purposes. Furthermore, starting in 2019, Medicare Part B claims measures can only be submitted by clinicians in a small practice (i.e., 15 or fewer eligible clinicians).

To meet data submission requirements and data completeness criteria, physicians must report at least 6 measures, or one specialty measure set, and report each measure for at least 60% of applicable patients. In addition to the 6-measure requirement, groups of 16 or more eligible clinicians and that meet a case minimum of at least 200 cases, will be subject to the 30-day all-cause hospital readmission measure. This measure will automatically be calculated using administrative claims data and would be counted in addition to the quality reporting requirement.

<table>
<thead>
<tr>
<th>2019 Quality Category Requirements</th>
<th>Minimum of 6 individual measures, including one outcome measure or a high-priority measure if an outcome measure is not available</th>
<th>Intermediate outcome measures count as an outcome measure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High-priority measures are defined as appropriate use, patient safety, efficiency, patient experience, care coordination, and opioid-related measures</td>
<td>There are a total of 39 specialty measure sets available for 2019 reporting</td>
</tr>
<tr>
<td>OR alternatively (to the 6 individual measures) report one specialty measure set</td>
<td>Report each measure for at least 60% of applicable patients (report data for that measure for at least 60% of the patients who meet the measure's denominator criteria, discussed in detail below)</td>
<td></td>
</tr>
</tbody>
</table>
What are some considerations for the full-year performance period?

For 2019 MIPS participation, the quality category score will be assessed using full calendar year patient data. Full-year performance period does not require full calendar year reporting beginning January 1, 2019. The full-year performance period means that patient data from the full calendar year will be used to assess whether physicians and other clinicians satisfy the data completeness criteria for the quality measures they are reporting. The data completeness criteria must first be satisfied to receive a performance score for a measure.

As you collect and report data, keep in mind that you must meet the 60% data completeness criteria for measures based on full-year patient data. However, you may report more than the required 60% if you choose.²

How do you satisfy the data completeness criteria?

![Quality breakdown of “60% of applicable patients” requirement](image)

Do only Medicare Part B patients count towards “applicable patients” or does this include all patients from all payers? This depends on the reporting mechanism:

- Claims – Medicare Part B patients
- Qualified Clinical Data Registry (QCDR), qualified registry, and CEHRT – Patients from all payers, including Medicare (all-payer mix)

² CMS set the threshold at 60% rather than at 100% to reduce reporting burden and to accommodate for operational issues that may arise during data collection during the initial years of the QPP. However, CMS intends to increase the threshold in future years.
Note: the “60% of applicable patients” requirement is not the same as the performance score which determines the number of points you will receive for each measure.

The performance score for each measure is determined by looking at the number of patients that meet the denominator criteria for whom the measure is reported and who are not excluded and seeing for how many of those patients you performed a clinical action that could satisfy the measure (the numerator for the measure). Your numerator/denominator performance will then be compared to the benchmark for the measure, and you will receive points for that measure based on how you performed in relation to the historical benchmark.³

How is the quality category scored?

Generally, physicians will receive 1-10 points for each measure they report, based on whether they satisfy the 60% data completeness criteria and their performance in a measure compared to the measure’s benchmark. Solo practitioners and small practices of 15 or fewer eligible clinicians (ECs) will automatically receive 3 points for submitting some information on a measure, while practices with more than 15 ECs will automatically receive 1 point for submitting some information on a measure.

If the 60% threshold is met, then physicians will have the opportunity to earn additional points per measure based on their performance as compared to the measure’s benchmark.

If the 60% threshold is not met, then physicians will receive only 1 or 3 points per measure based on their practice size.

In order to receive a performance score beyond 1 or 3 points per individual quality measure, you must meet the data completeness criteria of “60% of applicable patients,” meet the case minimum requirement of at least 20 cases per measure, and the measure must have a benchmark. If you report CAHPS for MIPS survey data, the 60% data completeness threshold does not apply and a range of 3-10 points will be available for each summary survey measure.

³ To review benchmarks for each measure, refer to the 2019 Quality Benchmarks zip file on CMS’s OPP Resource Library. For quality measures that are reportable through more than one reporting mechanism, please note that the benchmarks vary and selecting one method over another can impact your performance score.
Topped Out Measures

For quality measures designated as “topped out”, only a maximum of 7 points can be earned. Topped out measures are defined as measures for which performance is consistently high that “meaningful differences and improvement in performance can no longer be seen.” 2019 topped out measures include, but are not limited to, the following:

- Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin
  Quality Measure ID: 21
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
  Quality Measure ID: 23
- Image Confirmation of Successful Excision of Image-Localized Breast Lesion
  Quality Measure ID: 262
- Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy
  Quality Measure ID: 52

Extremely Topped Out Measures

Starting in 2019, measures designated as “extremely topped-out measures” will be proposed for removal, in total, and are not subject to the 4-year lifecycle applied to topped-out measures. Measures are considered “extremely topped-out” when their mean performance is within the 98th and 100th percentile range. Measures which meet this percentile benchmark can be located within the “2019 Quality Benchmarks” zip file available on the CMS QPP Resource Library.

Measures with No Benchmark

For quality measures with no historical benchmark, CMS will calculate benchmarks based on 2019 data. If no benchmark can be calculated, then only a maximum of 3 points can be earned for the measure, as long as data completeness has been met.

All-Cause Readmission Measure

For groups of 16 or more eligible clinicians who are subject to the 30-day all-cause readmissions measure and meet the case minimum of at least 200 cases, the benchmark and eligible points will be provided by CMS in early 2019. For CAHPS for MIPS summary survey measures, CMS will calculate benchmarks based on 2019 data and will provide them when available at the end of the performance period.

Bonus Points

Additionally, bonus points can be earned by reporting additional high-priority measures, reporting measures as an individual/small group provider, or reporting measures electronically using an EHR, qualified registry, or a QCDR, and through improvement scoring in the quality category.
What is the minimum I have to report for the quality category only and avoid the MIPS negative 7% payment adjustment in 2021?

The 2019 MIPS performance threshold is 30 points, meaning physicians must achieve at least 30 points in their overall MIPS final score for 2019 participation to avoid a negative payment adjustment in 2021. There are several ways to achieve 30 points using different MIPS categories. However, physicians can satisfy this requirement, and avoid a negative payment adjustment in 2021, by only reporting data for the quality category. For example, 2 minimum reporting options to satisfy the 30-point threshold include:

- Earning a minimum of 8 points for 5 measures that have benchmarks and are not topped out, OR
- Earning the maximum 10 points for a high-performance score for at least 4 measures that have benchmarks and are not topped out measures.

What measures to report?

MIPS Specialty-Specific Measure Sets

Reporting a specialty-specific measure set may be the least burdensome option if an applicable specialty-specific measure set exists.

There are 39 specialty measure sets available for 2019 reporting.
If the measure set contains more than 6 measures, you are only required to report on 6 total measures (at least one of which must be an outcomes or high-priority measure).

If the measure set contains less than 6 measures, then you are only required to report on applicable measures. For example, a measure set may only have 4 measures, and only 3 of those 4 measures are applicable to your practice, then you are only required to report those 3 measures.

Additional details on these specialty-specific measure sets are available using the Specialty Measure Set Overview on the PAI website and on CMS’s Quality Payment Program website.

**MIPS and QCDR Individual Measures**

There are 257 MIPS individual measures, across all specialties and settings, available for 2019 reporting. Visit the CMS measures search tool for a list of all MIPS measures, which can also filter the measures by specialty. In addition to MIPS measures, you also have the option to report 6 QCDR measures or a combination of 6 QCDR and MIPS measures. For some physicians, QCDRs may offer more applicable measures based on specialty, condition, practice setting, etc.

Download the Clinical “Quality Measure Specifications and Supporting Documents” zip file, located in the CMS’s QPP Resource Library. For additional details contact the Measure Steward listed for a particular measure.

These measures specifications will provide a blueprint for each measure with detailed information such as the denominator criteria (patient population), numerator criteria (clinical action), documentation requirements (important for potential audits), and rationale with the evidence base and/or or intent for the measure, among other key information.
Common MIPS Measures

While more applicable, specialty-specific measures may be available for your practice, below are 6 measures that CMS has identified as cross-cutting measures that are broadly applicable regardless of specialty. However, you do not have to report on these measures if they do not apply to you or if you prefer to report on other measures.

Cross-Cutting Measures

- #47 – Care Plan ................................................................. 12
- #128 – Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up Plan ........................................... 13
- #130 – Documentation of Current Medications in the Medical Record ............................................................. 15
- #226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention .................. 16
- #236 – Controlling High Blood Pressure ............................................................................................................. 17
- #317 – Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented ............................................................. 19

As you evaluate which measures to report, these measures provide a good starting point. In the Appendix you will find the reporting specifications (extracted from official 2019 CMS measure specifications documents) for each of these measures for claims and registry reporting, along with flow-chart diagrams from CMS that walk you through the specifications and reporting.

CAHPS for MIPS Summary Survey Measures

A group of 2 or more eligible clinicians that wishes to voluntarily elect to participate in the CAHPS for MIPS survey measure must use a survey vendor that is approved by CMS. The 2019 CAHPS for MIPS survey will conducted by the survey vendor from October 2019 to January 2020. The CAHPS for MIPS survey counts for one measure towards the MIPS quality category, as a patient experience measure, and also fulfills the requirement to report at least one high priority measure in the absence of an applicable outcome measure. Additionally, the group will be required to submit at least 5 other measures through another reporting mechanism. This mechanism requires registration with CMS by June 30, 2019. For additional details, see the CMS 2019 CAHPS for MIPS Overview Fact Sheet.

30-Day All-Cause Hospital Readmission Measure

The 30-day all-cause readmission measure is a risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized and experienced an unplanned readmission for any cause.
to a short-stay acute-care hospital within 30 days of discharge. In addition to the 6-measure requirement, groups of 16 or more eligible clinicians that meet the case minimum of at least 200 cases for the 30-day all-cause readmission administrative claims measure will automatically be scored and have that measure score included in their quality category performance score. For additional details about the 30-day all-cause readmission measure, search for the measure on CMS QPP Measures List.

How do I report data and by when?

You have several options for reporting quality category measures data. How you report the information will depend on the reporting mechanism you decide to choose.

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td></td>
</tr>
<tr>
<td>Individual (themselves or working with a Qualified Registry, QCDR, or CEHRT)</td>
<td>Medicare Part B Claims; Direct; Log-In and Upload</td>
</tr>
<tr>
<td>Group or Virtual Group (themselves or working with a Qualified Registry, QCDR, or CEHRT)</td>
<td>Medicare Part B Claims (only for those with small practice designation); Direct; Log-In and Upload; CMS Web Interface (for 25 or more ECs); CAHPS for MIPS Survey; Administrative Claims</td>
</tr>
</tbody>
</table>

However, not all measures can be reported using all reporting mechanisms. For example, some measures may not be available for claims reporting, but can be reported using a registry.

If reporting using the claims, qualified registry, or QCDR options, you will need to check CMS’s QPP measures specifications lists (discussed above) to identify measures that are reportable through your reporting mechanism of choice.

If reporting using CEHRT, please check with your CEHRT vendor about which quality measures they allow you to report electronically using the CEHRT. For the CEHRT reporting mechanism, measure specifications are available on the CMS eCQI Resource Center. When you visit the website, select “2019” to ensure you are reviewing the correct information for the 2019 MIPS quality category.

What’s the difference between the “claims” and “administrative claims” mechanisms?

Claims reporting for the MIPS quality category requires eligible clinicians to append quality data codes (QDCs) to denominator eligible Medicare Part B claims to indicate the required quality action or exclusion occurred. This mechanism is only an option if you report data for the quality category at the individual level. Whereas, administrative claims data is data that is already
available from billings on Medicare claims without appending QDCs. The administrative claims mechanism is used by CMS for the 30-day ACR measure for groups of 16 or more eligible clinicians.

The chart on the next page, provides clarification on how the data is reported for each mechanism, and also includes some key points you may want to take into consideration as you determine the best reporting mechanism option for you/your practice.

**What are my reporting deadlines?**

<table>
<thead>
<tr>
<th>Claims reporting</th>
<th>CMS Web Interface</th>
<th>QCDB, registry and CEHRT reporting mechanisms</th>
<th>CAHPS for MIPS survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Calims for services provided in 2019 must be processed by March 1, 2020</td>
<td>• January 2 - March 31, 2020</td>
<td>• March 31, 2020 (or sooner depending on your vendor’s own deadlines)</td>
<td>• Will be administered to beneficiaries from October 2019 through January 2020 • Will be communicated to you by your CMS-approved vendor of choice</td>
</tr>
</tbody>
</table>

**Where can I go for more information?**

Please visit [PAI’s QPP Resource Center](#) and the [CMS’s QPP Resource Library](#) for additional information and resources.
APPENDIX

#47 – Care Plan

SAMPLE CALCULATIONS:

Data Completeness = \[\frac{\text{Performance Met (a + b)} - \text{Performance Not Met (c)}}{\text{Eligible Population / Denominator}}\] = \[\frac{70}{90}\] = 77.78%

Data Completeness Numerator = \[\frac{70}{70}\] = 100%

Performance Rate = \[\frac{\text{Performance Met (a + b)}}{\text{Eligible Population / Denominator}}\] = \[\frac{70}{90}\] = 77.78%
#128 – Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up Plan

Denominator

Start

Patient Age at Date of Service ≥ 18 Years

No

Encounter Codes as Listed in Denominator*
(1/1/2019 thru 12/31/2019)

Yes

Telehealth Modifier: GQ, GT, 95, POS 12

Yes

BMI Not Documented, Patient Not Eligible** G3422 or equivalent

Yes

BMI Documented Outside of Normal Limits, Follow-Up Plan Not Documented, Patient Not Eligible** G3438 or equivalent

No

Include Eligible Population/Denominator (80 patients)

No

Numerator

BMI** Documented as Normal, No Follow-Up Plan** Required

Data Completeness Met + Performance Met G3420 or equivalent (20 patients)

No

BMI** Documented as Above Normal Parameters, And Follow-Up Plan** Documented

Data Completeness Met + Performance Met G3417 or equivalent (20 patients)

No

BMI** Documented As Below Normal Parameters, And Follow-Up Plan** Documented

Data Completeness Met + Performance Met G3418 or equivalent (10 patients)

No

Go To Next Page

* See the posted Measure Specification for specific coding and instructions to submit this measure.

** See the posted Measure Specification for specific BMI and follow-up plan definitions, eligibility exclusion criteria, and denominator exception criteria for this measure.

NOTE: Submission Frequency: Patient-Intermediate

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The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specifications.
SAMPLE CALCULATIONS:

Data Completeness=
Performance Met (c^2 > c^2=50 patients) + Denominator Exception (b = 0 patients) + Performance Not Met (c^2+c^2=50 patients) = 70 patients = 67.50%

Performace Rate=
Performance Met (c^2 > c^2=50 patients) = 50 patients = 71.43%

Data Completeness Numerator(70 patients) - Denominator Exception (b = 3 patients) = 70 patients

** See the posted Measure Specification for specific coding and instructions to submit this measure.

* See the posted Measure Specification for specific BMI and follow-up plan definitions, eligibility exclusion criteria, and denominator exception criteria for this measure.

NOTE: Submission Frequency: Patient-Intermediate
#130 – Documentation of Current Medications in the Medical Record

**Denominator**

- Start
- Patient Age on Date of Service ≥ 218 Years
  - No
  - Not Included in Eligible Population/Denominator
- Encounter as Listed in Denominator* (1/1/2019 thru 12/31/2019)
  - Yes
  - Include in Eligible Population/Denominator (80 visits)
  - a
  - Yes
  - b
  - No
  - c
- b

**Numerator**

- Current Medications List Obtained, Updated, Reviewed, and Documented in Medical Record
  - Yes
  - Data Completeness Met + Performance Met G84.27 or equivalent (40 visits)
  - No
  - Data Completeness Met + Denominator Exception G84.36 or equivalent (10 visits)
  - Current Medications List Not Documented as Obtained, Updated, or Reviewed, Patient Not Eligible
  - Yes
  - Data Completeness Met + Performance Not Met G84.26 or equivalent (20 visits)
  - No
  - Data Completeness Not Met Quality Data Code or equivalent not submitted (10 visits)

### SAMPLE CALCULATIONS:

\[
\text{Data Completeness} = \frac{\text{Performance Met (a=40 visits) + Denominator Exception (b=10 visits) + Performance Not Met (c=20 visits)}}{\text{Eligible Population / Denominator (d=80 visits)}} = 79 \text{ visits} = 67.50\%
\]

\[
\text{Performance Rate} = \frac{\text{Data Completeness Numerator (79 visits) - Denominator Exception (b=10 visits)}}{\text{80 visits}} = 69 \text{ visits} = 66.67\%
\]

*See the posting Measure Specification for specific coding and instructions to submit this measure.

**NOTE:** Submission Frequency: Visit

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#226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

**Flowchart:**

1. **Start**
2. **Denominator**
   - Patient Age ≥ 18 Years
   - Not Included in Eligible Population/Denominator
   - At Least One Preventive Encounter as Listed in Denominator* (1/1/2019 thru 12/31/2019)
3. **Numerator**
   - Patient Screened for Tobacco Use AND Identified as a Tobacco User
   - Patient Screened for Tobacco Use AND Identified as a Tobacco Non-User
   - Documentation of Medical Reason(s) for Not Screening for Tobacco Use
   - Patient Not Screened for Tobacco Use, Reason Not Given

**Sample Calculations Submission Criteria One:**

- **Data Completeness**
  - Performance Met + Performance Not Met
  - Data Completeness Met: (a + a^2)/70 patients
  - Data Completeness Not Met: (b + b^2)/10 patients
  - Eligible Population: 100 patients

- **Performance Rate**
  - Performance Met: (a + a^2)/70 patients
  - Performance Not Met: (b + b^2)/10 patients

*See the posted Measure Specification for specific coding and instructions to submit this measure.
**In the event that the tobacco status is unknown submit G9955.
***24 encounters should be without the Telehealth modifier in order to be denominator eligible.
NOTE: Submission Frequency: Patient process.
#236 – Controlling High Blood Pressure

*See the posted Measure Specifications for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Intermediate
2019 Clinical Quality Measure Flow for Quality ID #236 NQF #0018:
Controlling High Blood Pressure

**SAMPLE CALCULATIONS:**

- **Data Completeness**
  - Performance Met (n = 30 patients) + Performance Not Met (c^2 + d^2 + c^4 = 60 patients) = 70 patients = 87.50%
  - Eligible Population / Denominator (D = 80 patients) = 80 patients

- **Performance Rate**
  - Performance Met (n = 30 patients) = 30 patients = 42.86%
  - Data Completeness Numerator (70 patients) = 70 patients

*See the posted Measure Specifications for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Intermediate
#317 – Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

SAMPLE CALCULATIONS:

Data Completeness

<table>
<thead>
<tr>
<th>Performance Met (3/5 = 60 patients) + Denominator Exception (b = 20 patients) + Performance Met (c / 2 = 20 patients)</th>
<th>Eligible Population / Denominator (d = 100 patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 patients = 90.00%</td>
<td>100 patients</td>
</tr>
</tbody>
</table>

Performance Rate

<table>
<thead>
<tr>
<th>Performance Met (a / b = 50 patients) + Denominator Exception (b = 20 patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 patients = 71.43%</td>
</tr>
</tbody>
</table>

Data Completeness Numerator (90 patients) + Denominator Exception (b = 20 patients) = 70 patients

* See the posted Measure Specification for specific coding and instructions to submit this measure.

** See the posted Measure Specification for documented reason(s) a patient is considered a Denominator Exclusion or a Denominator Exception.

*** See the posted Measure Specification for recommended specific blood pressure screening intervals, as well as definitions for exclusion criteria for this measure.

NOTE: Submission Frequency - Patient process