Scoring of Qualified Registry and QCDR Submissions to Quality Payment Program in Year 1 (2017)

CMS has received many questions regarding how submissions from 2017 Qualified Registries and QCDRs will be scored. We have written the attached "explainer" document to help you better understand scoring of Qualified Registry and QCDR submissions to the Quality Payment Program in Year 1 (2017). This document is provided for informational purposes only, and is not an official directive, guideline or rule.

Qualified Registry and QCDR submissions to the Quality Payment Program (QPP), either via API or the file upload page on the QPP website, will generate MIPS scores for each group or eligible clinician in the file. The MIPS standard scoring formula for 2017 performance year data consists of three categories: Improvement Activities, Advancing Care Information, and Quality. Each category has unique scoring rules, which are explained in the narrative below. The categories are then weighted and added together to create a final score.

The default weighting for MIPS score for the 2017 performance year is as follows:

- Improvement Activities – 15%
- Advancing Care Information – 25%
- Quality – 60%

The MIPS scoring formula for the 2017 performance year is:

Final Score = [Improvement Activities Score (Improvement Activities Weighting) + Advancing Care Information Score (Advancing Care Information Weighting) + Quality Score (Quality Weighting)]

A sample score looks like this: 54.8 = [30(.15) + 62(.25) + 58(.60)]

Significant rules regarding the scoring of Registry submissions

- A Registry submission is scored separately from other submission methods such as manual attestation and EHR.

- Subsequent Registry file submissions will overlay previous submissions by a Qualified Registry or QCDR for a group or eligible clinician.
- The most recent Registry submission by a Qualified Registry or QCDR is counted as the current and valid submission.
- A scoring category's submission is scored and viewed separately from other categories; the most recent score for each category is used in Final Score for the Registry and QCDR submission methods.
- The user from a Qualified Registry or QCDR will only see scores for data submitted by that Qualified Registry or QCDR.
- A user for a group or eligible clinician will see scores for any data submitted by them or on their behalf.
- QPP will use the highest score received for a group or eligible clinician across all submission methods for a Final Score.

Scoring for each category is described below.

Improvement Activities Scoring

A performance period of 90 days must be submitted to achieve a score.

The Improvement Activities category is based on a 40 point scale. If the submission obtains 40 points for the TIN or TIN/NPI combination, they will get 15 points for the Improvement Activities category toward their Final Score. If the submission obtains less than 40 points, it will be based around on the scores below:

- 30 points equals 11.25 points towards Final Score
- 20 points equals 7.5 points towards Final Score
- 10 points equals 3.75 points towards Final Score
- 0 points equals 0 points towards Final Score

An Improvement Activity is designated as either High, meaning 20 points, or Medium, meaning 10 points. The submission may contain any assortment of activities to get to 40 points to fulfill the requirements for the Improvement Activity category. For example, 1 High weighted activity and 2 Medium activities, will give the user 40 points. Submitting additional activities will be logged but the user cannot obtain more than 40 points in the category or 15 points toward Final Score. Please note that some Improvement Activities may be submitted with less than 90 days during the Transition Year.

Advancing Care Information Scoring

In order to obtain a score in the Advancing Care Information category, the submission must contain not only a performance period but also positive attestation for the first two attestation statements:

- Prevention of Information Blocking Attestation, and
- ONC Direct Review Attestation.

The Advancing Care Information category is based on a 100 point scale. Points are awarded based on data supplied for one of the following 2 options, to be determined by the submitter based on their EHR technology:

- Advancing Care Information Measures, and
- 2017 Advancing Care Information Transition Objectives and Measures.

For both Advancing Care Information Measures and 2017 Advancing Care Information Transition Objectives and Measures, having a performance period of 90 or greater days and answering the required Base Score Measures will provide a minimum set of points (for a maximum of 53 and 54 respectively). Additional points can be earned by providing data to the Optional Performance Scores, Additional Registry Bonus, or Advancing Care Information Improvement Activities Bonus.

Standard Quality Scoring

In order to be scored in quality, the submission must include a performance period. In addition, all groups (regardless of size) as well as eligible clinicians, are required to submit a minimum of 6 measures, one of which must be:

- An outcome measure, if available, otherwise,
- A high priority patient experience measure, or
- Another high priority measure (appropriate use, patient safety, efficiency, and care coordination).

Failure to submit one of these measures will result in the lowest scored measure receiving 0 points.

A specialty set can also be reported. If the set contains less than 6 measures, all measures in the set must be reported. If the set contains more than 6 measures at least six must be reported.

For measures submitted via registry a measure validation process can be applied to determine if fewer than 6 measures are available and applicable.

Quality measures scoring is based on a performance score being compared against a measure's benchmark to create a score of between 3-10 points per measure. If the submission contains the minimum number of measures (6) which meet the submission criteria, each measure can achieve the maximum number of measure points (10) and

the submission can achieve the maximum total number of points for the quality performance category score (60) for a group or eligible clinician.

Benchmarks

Quality scoring under MIPS incorporates the use of benchmarks to evaluate a group or an eligible clinician by comparing them to a metric created by the scores of their peers.

An attempt to create an historical benchmark for each submission type and measure will be made based on data submitted in a previous performance year (baseline period). For the first year of MIPS with the scoring based on the submission of 2017 data, the historical benchmark will be based on data submitted for the 2015 performance year.

For measures that do not have benchmarks, QPP will attempt to create a benchmark from the data submitted for 2017. This will occur after the submission period ends. If insufficient data exists, then no benchmark will exist and the score for the measure will be a maximum of 3 points.

Individual measure scoring using the benchmark

Single-Performance Rate or Multi-Performance Rate will produce a performance rate based on the submitted measure data. The performance rate is compared to benchmark data to find which decile the performance rate falls into, with the decile equaling the number of points. Partial points may be added based on where the performance rate falls between lower bounds of deciles. Some QCDR measures will not output a performance rate and will be submitted with the Non-Proportion Measurements type. For additional information around submission type and performance rate calculation, please visit the QPP site.

Calculation of Total Quality Score

Calculation of the Quality score will be based on the highest scoring 6 measures. If the submission does not contain 6 measures for which a measure score can be determined, the calculation will substitute a zero score for the missing measure scores.

To calculate the Quality score:

1. Calculating High Priority Bonus Points
    a. Add 2 points to the total quality score for every outcome or high priority patient experience measure submitted after first outcome or high priority patient experience measure.
    b. Add 1 point to the total quality score for every remaining measure in the high priority measure category, if outcome or patient experience submitted. If no outcome or high priority patient experience measure is

submitted, bonus points will be awarded for every high priority after the first submitted measure.

c. High priority bonus points are capped at 10% of the denominator (total possible points the MIPS eligible clinician or group could receive in the quality performance category).

2. For the end-to-end reporting bonus, add 1 point to the total quality score for every measure submitted using end-to-end electronic reporting.
3. The 6 highest scored measures are selected for inclusion in the total quality score. If the high priority requirement is not met, the lowest scoring measure out of the 6 measures selected will be awarded 0 points for failure to comply.
4. Create the total Quality Score: add the 6 measures scores together, plus all bonus points and divide by 60. If a validation process is conducted for measures submitted via registry, the denominator will be adjusted based on the available measures. The denominator will also be adjusted if a specialty set with fewer than 6 measures is reported.
5. Groups of 16 or more that also meet the all-cause readmission measure case minimum have 70 possible points for the denominator.

Scoring for Special Scenarios

Please be aware that the Standard Quality Scoring section above describes the default scoring rules which will be used to determine the score at the time of submission. Scores returned by the Submission API or displayed in the Submission file upload section of the QPP website will be calculated using these default scoring rules. There are certain special scenarios that may cause the score for a TIN or TIN/NPI on whose behalf a Qualified Registry or QCDR is submitting to change after submission. Below is a list of special scenarios that may impact scoring after submission:

- Participation in an Alternative Payment Model,
- Group or individual has been identified with a special status (i.e., Non-Patient Facing Practice, Small Practice, Rural Area Practice and Health Professional Shortage Area),
- Application and approval of score reweighting,
- Natural Disaster Impact,
- Practice Type (i.e., Physician Assistant, CRNP, CRNA, CNS, ASC, NP),
- Improvement Activity Study participant,
- CAHPS participant.

More information about special scoring, please visit the QPP Eligibility Page.