Quality Payment
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2024 Qualified Clinical Data Registry (QCDR) & Qualified Registry Kickoff

April 11, 2024
9 a.m. - 4:00 p.m. ET

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Welcome

Dr. Daniel Green, Centers for Medicare & Medicaid Services (CMS)

2023 Data Submission Reminder

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Reminder: 4 Days Until the Close of the 2023 MIPS Data Submission Period

The Centers for Medicare & Medicaid Services (CMS) opened data submission for Merit-based Incentive Payment System (MIPS) eligible clinicians who participated in the 2023 performance year of the Quality Payment Program (QPP). Data can be submitted and updated until **8:00 p.m. ET on April 15, 2024.**

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Kickoff Information

Anastasia Robben, Merit-based Incentive Payment System (MIPS) QCDR/Registry Support Team (Practice Improvement and Measures Management Support (PIMMS) Team)

Kickoff Information

Attendance Tracking Information

In-Person Attendance Information

Webinar Information

Question & Answer Information

Disclaimer

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This publication is a general summary that explains certain aspects of the Medicare Program but isn't a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

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Agenda

- Quality Payment Program (QPP) Overview
- MIPS Overview
  - Quality Performance Category
  - Cost Performance Category
  - Improvement Activities Performance Category
  - Promoting Interoperability Performance Category
- MIPS Value Pathways (MVPs) Overview
- Alternative Payment Model (APM) Overview
- Medicare Shared Savings Program Overview
- QCDR & Qualified Registry Overview & Timeline
- QCDR & Qualified Registry Feedback
- Doctors & Clinicians Public Reporting
- Quality Measures Overview
- Roles & Access in QPP
- Tech Talk
- Scoring Overview
- Resources & Who to Contact for Assistance

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Quality Payment Program (QPP)

Dr. Daniel Green, CMS

What is the Quality Payment Program (QPP)?

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. MACRA-advances a forward-looking, coordinated framework for clinicians to successfully participate in the QPP, which rewards value in 1 of 2 ways:

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

Beginning in 2024, if you participate in an Advanced APM and achieve Qualifying APM Participant (QP) status, you may be eligible for an increased QP conversion factor and will be excluded from MIPS.

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Merit-based Incentive Payment System (MIPS)

Dr. Daniel Green, CMS

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

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MIPS is one way to participate in QPP. Under MIPS, we evaluate your performance across multiple categories that lead to improved quality and value in our healthcare system.

Promoting Interoperability

Assesses your promotion of patient engagement and electronic exchange of health information using certified electronic health record technology (CEHRT).

Improvement Activities

Assesses your participation in activities that improve clinical practice and support patient engagement.

Quality

Assesses the quality of care you deliver based on measures of performance.

Cost

Assesses the cost of the care you provide based on your Medicare Part B claims.

For a high-level overview and actionable steps of MIPS, review the 2024 MIPS Quick Start Guide.

Performance Category Weights

Performance Category	Performance Category Weights		
	2024 Traditional MIPS and MVPs Individuals, Groups, Virtual Groups (no change)	2024 Traditional MIPS and MVPs APM Entities (no change)	2024 APM Performance Pathway (APP) Individuals, Groups, APM Entities (no change)
Quality	30%	55%	50%
Cost	30%	0%	0%
Improvement Activities	15%	15%	20%
Promoting Interoperability	25%	30%	30%

The APP has different scoring weights compared to APM Entities participating in traditional MIPS.
When an APM Entity reports traditional MIPS, CMS will reweight the quality performance category to 55% according to traditional MIPS performance category reweighting rules, as opposed to 50% under the APP.

Reporting Options

There are 3 reporting options available to MIPS eligible clinicians:

- Traditional MIPS, established in the first year of the Quality Payment Program, is the original MIPS reporting option. You select the quality measures and improvement activities that you'll collect and report from the complete MIPS inventory. You report the complete set of Promoting Interoperability measures and attestations. We collect and calculate data for the cost performance category for you.

- The Alternative Payment Model (APM) Performance Pathway, or APP, is a streamlined reporting framework, with a specified quality measure set, available to clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs.

- MIPS Value Pathways (MVPs) are the newest way to fulfill MIPS reporting requirements. MVPs include a subset of measures and activities that are related to a given specialty or medical condition. MVPs offer reduced reporting requirements, allowing MVP participants to report on a smaller, more cohesive subset of measures and activities (within the measures and activities available for traditional MIPS).
    - There are 16 MVPs available to report for the 2024 performance year.

For a more information on the Reporting Options, visit the Reporting Options Overview webpage on the Quality Payment Program website.

Participation Options

"Participation options" refers to the levels at which data can be collected and submitted, or "reported", to CMS for MIPS. There are 5 participation options available for MIPS

- **Individual:** Collect and submit data for an individual MIPS eligible clinician.
- **Group:** Collect and submit data for all clinicians in the group.
- **Virtual Group:** Collect and submit data for all clinicians in a CMS approved virtual group (traditional MIPS only). Virtual group elections are submitted to CMS prior to the performance year – the virtual group election period for the 2024 performance year closed on December 31, 2023.
- **APM Entity:** Collect and submit data for MIPS eligible clinicians identified as participating in the MIPS APM.
- **Subgroup:** This participation option is only available to clinicians reporting an MVP. Advance registration is required.

For a more information on the reporting options, visit the Participation Options Overview webpage on the QPP website.

Performance Threshold & Payment Adjustments

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2023 Final

Final Score 2023	Payment Adjustment 2025
75.01-100 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
75 points	• Neutral payment adjustment
18.76-74.99 points	• Negative payment adjustment between -9% and 0%
0-18.75 points	• Negative payment adjustment of -9%

2024 Final

Final Score 2024	Payment Adjustment 2026
75.01-100 points	• Positive adjustment greater than 0% • (Scaling factor applied to meet statutory budget neutrality requirements)
75 points	• Neutral payment adjustment
18.76-74.99 points	• Negative payment adjustment between -9% and 0%
0-18.75 points	• Negative payment adjustment of -9%

The 2022 performance year/2024 MIPS payment year was the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance.

Timeline

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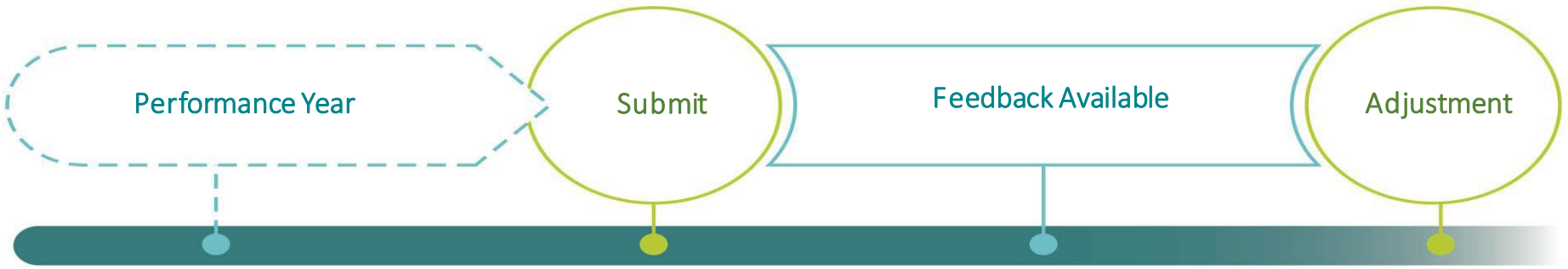

2024 Performance Year
Jan. 1 – Dec. 31, 2024
Clinicians care for patients and record data.

To Do:

- Check initial eligibility (January 2024).
- Select a reporting option.
- Choose a participation option.
- Collect quality measure data (January - December).
- Perform improvement activities (generally 90 days).
- Collect Promoting Interoperability data (180+ days).
- Check final eligibility (December 2024).

2025 Data Submission
Jan. 2 - March 31, 2025
Submit data collected in the performance year.

To Do:

- Get a HARP account and QPP access (November 2024).
- Sign in to the QPP website (January – March 2025) to Attest to performing improvement activities.
- Upload your measure/activity file or view data submitted on your behalf.
- View any Medicare Part B claims measures you reported throughout 2024.

2025 Performance Feedback
Summer 2025
Review final score and payment adjustment.

To Do:

- Sign in to the QPP website to view your performance feedback and payment adjustment information
- Submit a targeted review request if you find any scoring errors (you have approximately 60 days to do this once final scores are released).

2026 Payment Adjustment
Jan. 1 – Dec. 31, 2026
Payment adjustments applied.

To Do:

- MIPS eligible clinicians will receive a positive, negative, or neutral adjustment in the 2026 payment year based on their 2024 MIPS final score.
- MIPS payment adjustments are applied on a claim-by-claim basis to covered professional services billed under the Physician Fee Schedule.

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Quality Performance Category

Dr. Daniel Green, CMS

Quality Performance Category

The quality performance category measures your performance on clinical practices and patient outcomes. The quality measures are tools that help us assess healthcare processes, outcomes, and patient experiences to ensure they align with our quality goals for healthcare.

The quality performance category has a 12-month performance period (January 1 – December 31, 2024), which means you must collect data for each measure for the full calendar year

For a high-level overview and practical information about quality measure selection, data collection and submission for the 2024 MIPS quality performance category, review the 2024 Quality Quick Start Guide (PDF 981KB).

Quality Reporting Requirements

Traditional MIPS	MVPs
Select a minimum of 6 quality measures (including 1 outcome or high priority measure) from the complete MIPS quality measure inventory. OR Report 1 complete specialty measure set. Did you know? • If the specialty set includes fewer than 6 measures, you'll meet reporting requirements if you report all the measures in the specialty set.	Select a minimum of 4 quality measures (including 1 outcome or high priority measure) from your chosen MVP. Did you know? • For small practices reporting through Medicare Part B claims, if your selected MVP includes fewer than 4 Medicare Part B claims measures available, you don't need to report additional measures to meet quality reporting requirements.

2024 MIPS Finalized Policies

Quality Measures

CMS finalized an inventory of 198 MIPS quality measures for the 2024 performance year:

- Addition of 11 MIPS quality measures, including 1 composite measure and 6 high priority measures, of which 4 are patient-reported outcome measures.
- Substantive changes to 59 existing MIPS quality measures.
- Removal of 11 MIPS quality measures and partial removal of 3 MIPS quality measures (3 measures removed from traditional MIPS and retained for MVP use only).

QCDR measures aren't included in the above measure inventory.

New collection type available for Shared Savings Program ACOs

2024 MIPS Finalized Policies

Collection Types Available for Shared Savings Program ACOs Reporting the APP

2023 Final	2024 Final
• Shared Savings Program ACOs can report their quality measures under the APP using the following collection types for the 2024 performance year: ○ CMS Web Interface Measures ○ Electronic Clinical Quality Measures (eCQMs) ○ MIPS Clinical Quality Measures (MIPS CQMs).	• We finalized the establishment of a new collection type (the way in which data is collected for a measure), specifically for ACOs: Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program, which can only be reported under the APP. • The following collection types are now available: ○ CMS Web Interface Measures* ○ eCQMs ○ MIPS CQMs ○ Medicare CQMs**

*The 2024 performance year will be the final year for Shared Savings Program ACOs to report the CMS Web Interface measures.

**Under the Medicare CQM collection type, an ACO that participates in the Shared Savings Program is required to collect and report data on only the ACO's eligible Medicare fee-for-service (FFS) beneficiaries that meet the definition of a beneficiary eligible for Medicare CQM at § 425.20, instead of its all payer/all patient population.

2024 MIPS Finalized Policies

Data Completeness

2023 Final	2024 Final
• Increase to the data completeness threshold to 75% for the 2024 and 2025 performance years.	• Maintain the data completeness threshold of 75% for the 2026 performance year, which is applicable to eCQMs, MIPS CQMs, Medicare CQMs for ACOs, Medicare Part B claims measures, and QCDR measures. • The data completeness threshold of 75% for the 2024, 2025, and 2026 performance years also applies to Medicare CQMs collection type.

2024 MIPS Finalized Policies

International Classification of Diseases, 10th Revision (ICD-10) Coding Changes

2023 Final	2024 Final
• Measures are truncated (9-month performance period) when there's a more than 10% change in codes in the measure numerator, denominator, exclusions, and exceptions; clinical guideline changes or new products or procedures reflected in ICD–10 code changes effective October 1 each year. (In this circumstance, eCQMs have been suppressed.)	• We finalized modifications to the criteria used to assess ICD-10 coding updates by: ○ Eliminating the automatic 10% threshold of coding changes that triggers measure suppression or truncation. ○ Assessing the impact of coding changes on a case-by- case basis. ○ Assessing each collection type separately of a given measure in order to determine the appropriate action to take for a measure affected by an ICD-10 coding update.

2024 MIPS Finalized Policies

CAHPS for MIPS Survey

We're requiring groups, virtual groups, subgroups, and APM Entities to contract with a CAHPS for MIPS Survey vendor to administer the Spanish survey translation to Spanish-preferring patients using the procedures detailed in the CAHPS for MIPS Quality Assurance Guidelines.

We're also recommending that groups, virtual groups, subgroups, and APM Entities administer the CAHPS for MIPS Survey in the other available translations (Cantonese, Korean, Mandarin, Portuguese, Russian, and Vietnamese).

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Cost Performance Category

Ray Desautels, CMS

Cost Performance Category

The cost performance category is an important part of MIPS. Although clinicians don't personally determine the price of individual services provided to Medicare patients, they can affect the amount and types of services provided. By ensuring that patients receive the right services through better care coordination and seeking to improve health outcomes, clinicians play a meaningful role in delivering high-quality care at a reasonable cost.

The cost performance category has a 12-month performance period (January 1 – December 31, 2024). You do not need to submit any data for the cost performance category, as CMS automatically calculates cost measures using administrative claims data.

For a high-level overview of cost measures, including calculation and attribution, for the 2024 MIPS cost performance category, review the 2024 Cost Quick Start Guide (PDF 1MB).

2024 MIPS Finalized Policies

Cost Measure Inventory

Adding 5 new episode-based cost measures, each with a 20-episode case minimum, including:

- An acute inpatient medical condition measure (Psychoses and Related Conditions);
- Three chronic condition measures (Depression, Heart Failure, and Low Back Pain);
- A measure focusing on care provided in the emergency department setting (Emergency Medicine).

Removing the acute inpatient medical condition cost measure Simple Pneumonia with Hospitalization, beginning with the 2024 performance year.

Beginning with PY 2023, we're calculating cost improvement at the category level (instead of measure-level as previously finalized).

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Improvement Activity Performance Category

Vidya Sellappan, CMS

Improvement Activity Performance Category

The improvement activities performance category assesses your participation in clinical activities that support the improvement of clinical practice, care delivery, and outcomes. With over 100 activities to choose from, you can select from the 2024 Improvement Activities Inventory to find those that best fit your practice and support the needs of your patients by improving patient engagement, care coordination, patient safety, and other areas in patient care.

For a high-level overview and practical information about data collection and submission for the 2024 MIPS improvement activities performance category, review the 2024 Improvement Activities Quick Start Guide (PDF 924KB).

2024 MIPS Finalized Policies

Improvement Activity Inventory

- Adding 5 new improvement activities
  - These additions include an MVP-specific improvement activity titled “Practice-Wide Quality Improvement in MIPS Value Pathways”.
- Modifying 1 existing improvement activity.
- Removing 3 existing improvement activities

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Promoting Interoperability Performance Category

Elizabeth Holland, CMS

Promoting Interoperability Performance Category

- Interoperability, or the use of technology to exchange and make use of information, makes communicating patient information less burdensome and improves outcomes. The MIPS Promoting Interoperability performance category emphasizes the electronic exchange of health information using certified electronic health record technology (CEHRT) to improve:
  - Patient access to their health information;
  - The exchange of information between clinicians and pharmacies; and
  - The systematic collection, analysis, and interpretation of healthcare data.

Discontinue automatic reweighting policy for certain clinician types

We'll continue to automatically reweight small, hospital-based and ambulatory surgical center-based clinicians.

2024 MIPS Finalized Policies

Reweighting

2023 Final	2024 Final
Discontinuing automatic reweighting for following clinician types beginning with 2023: • Nurse practitioners • Physician assistants • Certified registered nurse anesthetists • Clinical nurse specialists Continuing automatic reweighting for following clinician types in 2023: • Clinical social workers • Physical therapists • Occupational therapists • Qualified speech-language pathologists • Qualified audiologists • Clinical psychologists, and • Registered dieticians or nutrition professionals	Discontinuing automatic reweighting for following clinician types in the 2024 performance year: • Physical therapists • Occupational therapists • Qualified speech-language pathologists • Clinical psychologists • Registered dietitians or nutrition professionals Continuing automatic reweighting for the following clinician type in the 2024 performance year: • Clinical social workers

2024 MIPS Finalized Policies

Performance Period

2023 Final	2024 Final
The performance period is a minimum of 90 continuous days within the calendar year.	We finalized the increase of the performance period to a minimum of 180 continuous days within the calendar year.

2024 MIPS Finalized Policies

Query of Prescription Drug Monitoring Program (PDMP) Measure Exclusion

2023 Final	2024 Final
The current exclusion is available if a clinician or group "writes fewer than 100 permissible prescriptions during the performance period."	We finalized the modification of this exclusion to the following: • "Does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period."

2024 MIPS Finalized Policies

Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure

2023 Final	2024 Final
For the 2022 and 2023 performance years a "yes" or a "no" response fulfills the SAFER Guide measure.	We finalized to require a "yes" response for the SAFER Guide measure beginning with the CY 2024 performance year. • Clinicians need to conduct a self-assessment using the High Priority Practices SAFER guide as a review.

Reporting Promoting Interoperability for APM Entities reporting the APP

This performance category only counts toward the MIPS final score and therefore isn't required for Qualifying APM Participants (QPs) and Partial QPs that don't elect to report for MIPS.

For APM Entities that are Shared Savings Program ACOs, Promoting Interoperability will only be used for purposes of MIPS and will not be used for purposes of the Shared Savings Program.

- If an APM Entity includes MIPS eligible clinicians, the MIPS eligible clinicians will need to report Promoting Interoperability data, otherwise this performance category will contribute zero points toward their final MIPS score in the 2024 performance period.
- APM Entities (including Shared Savings Program ACOs) can submit data for this performance category at the APM entity level.
    - APM Entities have the option to report Promoting Interoperability data at the individual or group level in the APP and/or individual, group, virtual group, or APM entity level in traditional MIPS or MVPs.
    - If data isn't submitted at the APM entity level, individual and group data will be aggregated by QPP and averaged into a single score for the APM Entity.

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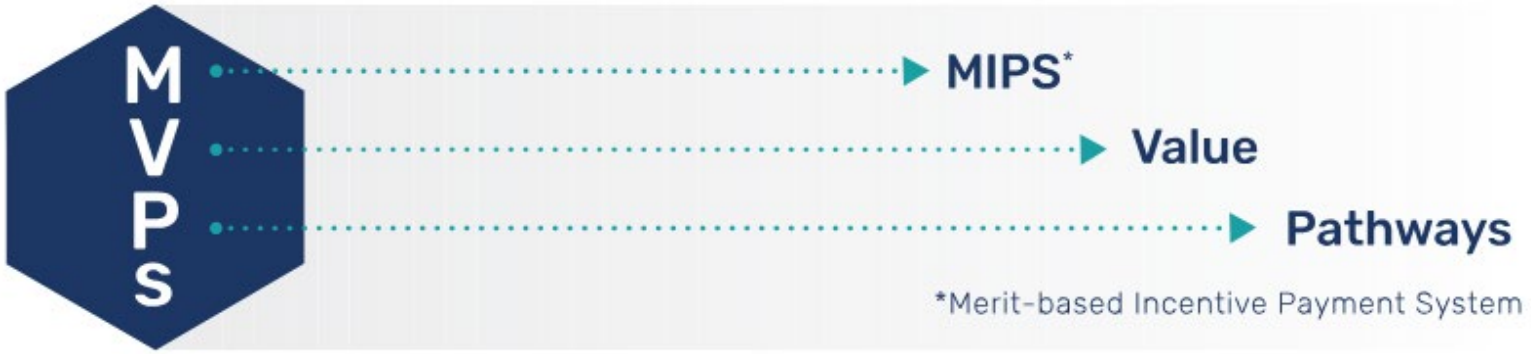
MIPS Value Pathways

Michelle Peterman, CMS

MVP Overview

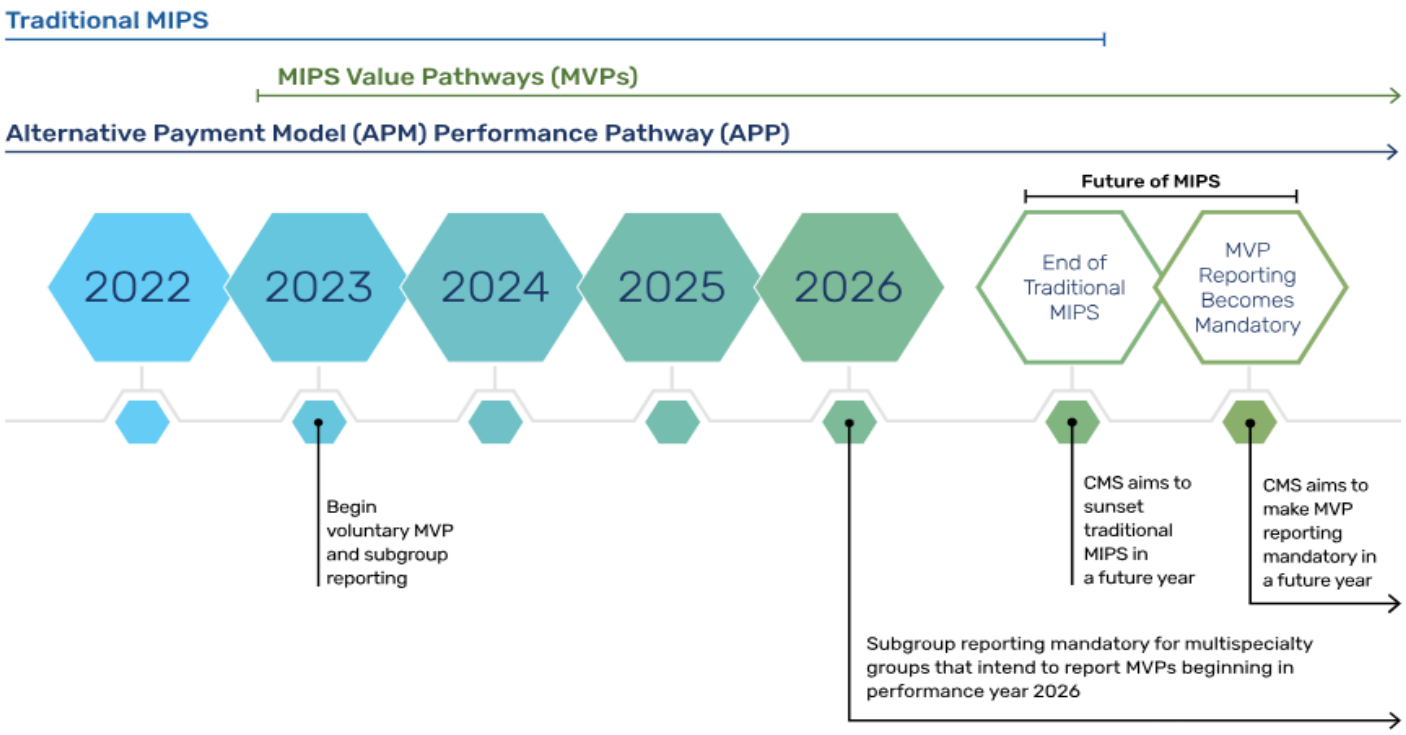
MVPs are the newest MIPS reporting option (an alternative to traditional MIPS and APM Performance Pathway (APP)) that you can use to meet your MIPS reporting requirements.

Each MVP includes a subset of measures and activities that are related to a given specialty or medical condition. Visit the Explore MVPs webpage to learn about the MVPs available for reporting.



MVP Overview

Starting in 2026, any multispecialty groups intending to report MVPs will be required to report as subgroups or individuals. CMS plans to sunset traditional MIPS in the future, at which point MVPs will become mandatory unless the clinician is eligible to report the APP.



2024 MIPS Finalized Policies

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MVP Candidates

CMS finalized 5 new MVPs and revised all previously established MVPs that will be available beginning with the 2024 performance year:

Newly Finalized MVPs
Focusing on Women's Health
Quality Care for the Treatment of Ear, Nose, and Throat Disorders
Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
Quality Care in Mental Health and Substance Use Disorders
Rehabilitative Support for Musculoskeletal Care

Previously Established MVPs
Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
Advancing Cancer Care
Advancing Care for Heart Disease
Advancing Rheumatology Patient Care
Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
Improving Care for Lower Extremity Joint Repair
Optimal Care for Kidney Health
Optimal Care for Patients with Episodic Neurological Conditions
Patient Safety and Support of Positive Experiences with Anesthesia
Value in Primary Care*
Supportive Care for Neurodegenerative Conditions

* This new MVP title reflects consolidation of previously existing MVPs: Optimizing Chronic Disease Management and Promoting Wellness

For more information, visit the Explore MVPs webpage.

2024 MIPS Finalized Policies

Quality Payment PROGRAM

Additions to MVP Development Process:

Broadened opportunity for the public to provide feedback on viable MVP candidates by posting draft versions of MVP candidates on the QPP website to solicit feedback for a 45-day period *(previously 30 days)*.

- CMS will review all feedback and determine if any changes recommended should be incorporated into a candidate MVP before it's potentially proposed in rulemaking.
- If CMS determines changes should be made, CMS won't notify the group or organization that submitted the original MVP candidate in advance of rulemaking.
- The MVP Candidate Feedback Process is open December 15 - January 29.

Review detailed instructions for MVP candidate development and formally submit MVP candidates for CMS consideration via the MVP Candidate Development & Submission webpage.

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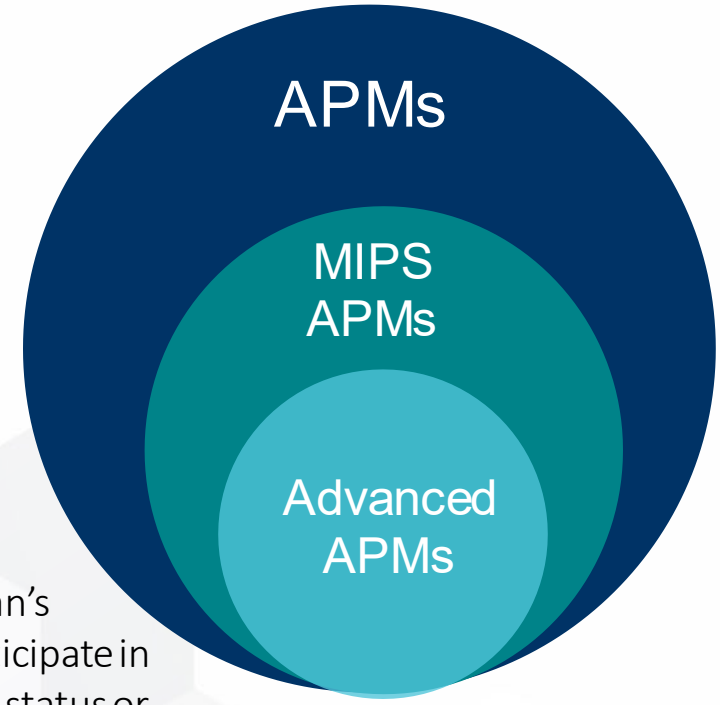
Alternative Payment Model (APM)

Richard Jensen, CMS

Alternative Payment Model (APM) Overview

Alternative Payment Model (APM) reward healthcare providers for delivering value-based care. They can apply to a specific:

- Health condition, like end-stage renal disease
- Care episode, like joint replacement
- Population, like primary care providers in Maryland



Types of APMs:

- APMs
- MIPS APMs
- Advanced APMs (APP)

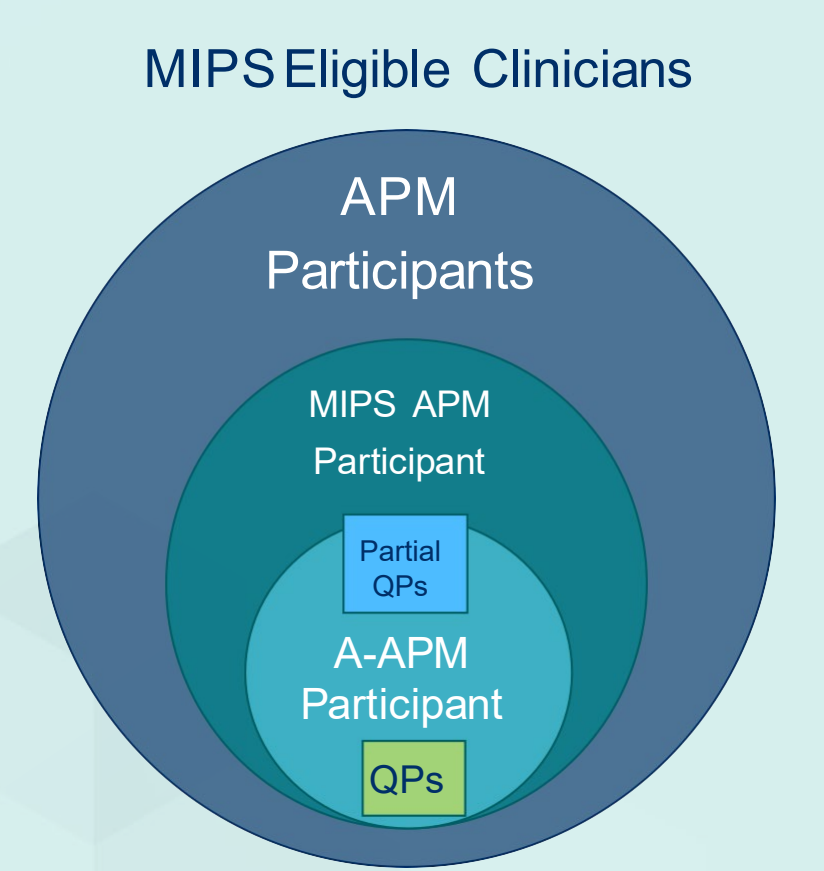
Note: The designation of the APM does not affect a clinician's eligibility for MIPS. APM participants will still need to participate in MIPS unless they receive Qualifying APM Participant (QP) status or are otherwise exempt.

For a more information on the Reporting Options, visit the Participation Options Overview webpage on the Quality Payment Program website.

Alternative Payment Model (APM) Overview

QPs are eligible clinicians who have met or exceeded the payment amount or patient count thresholds based on participation in an Advanced APM.

- They are exempt from reporting in MIPS and earn an APM Incentive Payment on Part B claims.
- *Note:* The designation of the APM does not affect a clinician's eligibility for MIPS. APM participants will still need to participate in MIPS unless they receive QP status or are otherwise exempt.



Qualifying APM Participant (QP) Determinations

QP thresholds are frozen through performance year 2024.

Performance Year	2021	2022	2023	2024
Payment Year	2023	2024	2025	2026
QP Payment Amount Threshold	50%	50%	50%	50%
QP Patient Count Threshold	35%	35%	35%	35%

To become a QP, clinicians must receive at **least 50 percent** of Medicare Part B payments or see at least 35 percent of Medicare patients through an Advanced APM Entity during the QP performance period (January 1 - August 31).

If you are not determined to be a QP or a Partial QP, you will be required to participate in MIPS and will be subject to a MIPS Final Score and payment adjustment, unless you are otherwise excluded. Visit QPP.cms.gov to learn more about MIPS.

Qualifying APM Participant (QP) Determinations

APM Participants who are MIPS eligible (i.e., not QPs) may report to MIPS however they choose:

- Individual
- Group
- Virtual Group
- MIPS APM Entity
  - APM Entities will have the cost performance category reweighted to 0% of their final MIPS score.

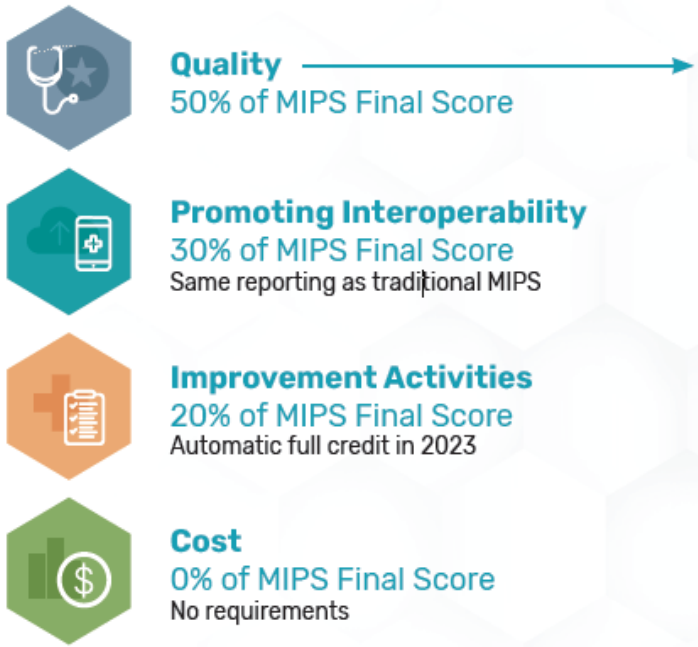
All participants in MIPS APMs also have the option to report to MIPS via the APP.

CMS Web Interface Updates

The CMS Web Interface will be sunset for Shared Savings Program ACOs after the 2024 performance period. Only Shared Savings Program ACOs are able to report using the CMS Web Interface for the 2023 and 2024 performance periods.

APM Performance Pathway (APP)

What Are the Reporting Requirements Under the APP?



APP participants will be scored on the following quality measure set:

- CAHPS for MIPS (Quality ID: 321)
- Hospital-Wide, 30-day, All Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Quality ID: 479)
- Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Measure ID: 484)
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (Quality ID: 001)*
- Preventative Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134)*
- Controlling High Blood Pressure (Quality ID: 236)*

Note: For the 2024 performance year, Shared Savings Program ACOs have the option to report the 10 CMS Web Interface measures (not reflected in the list above) or the 3 eCQMs/MIPS CQMs/Medicare CQMs.

You can find more information about the current quality reporting requirements for APP participants here: Quality Measures: APP Requirements PY 2021 (cms.gov)

Note: The APP is required for all Shared Savings Program ACOs. Quality data reported via the APP will be used to calculate Shared Savings Program scores, and MIPS Quality performance category scores between the 2 programs will be identical.

If you participate in a virtual group, you will receive a Final Score based on the performance of the virtual group, even if you have a higher score through another means of participation.

APM Performance Pathway (APP)

For individuals, groups, and APM Entities (excluding Shared Savings Program ACOs), the APP's quality measure set is finalized as:

- The CAHPS for MIPS measure,
- 2 administrative claims measures, and
- 3 quality measures (reported as eCQMs, MIPS CQMS, or Medicare Part B Claims measures).

For APM Entities that are Shared Savings Program ACOs, the APP's quality measure set is finalized as:

- The CAHPS for MIPS measure
- 2 administrative claims measures
- 3 quality measures (reported as eCQMs, MIPS CQMS, or Medicare CQMs) **OR** 10 quality measures (reported as CMS Web Interface measures)

Beginning with the 2024 performance period, Medicare CQMs have been established as a new collection type for Shared Savings Program ACOs that can be reported via the APP.

2024 Advanced APMs Finalized Policies

Use of CEHRT: To be an Advanced APM, the APM must require the use of certified EHR technology, which means EHR technology certified under the ONC Health IT Certification Program that meets: (1) the 2015 Edition Base EHR definition, or any subsequent Base EHR definition (as defined in at 45 CFR 170.102); and (2) any such ONC health IT certification criteria adopted or updated in 45 CFR 170.315 that are determined applicable for the APM, for the year, considering factors such as clinical practice areas involved, promotion of interoperability, relevance to reporting on applicable quality measures, clinical care delivery objectives of the APM, or any other factor relevant to documenting and communicating clinical care to patients or their health care providers in the APM.

Quality Payment
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Medicare Shared Savings Program

Ashley Burton Lockley, CMS

Medicare Shared Savings Program

Medicare CQMs

Quality Payment PROGRAM

For performance year 2024 and subsequent performance years, CMS established Medicare CQMs as a new quality measure collection type for Shared Savings Program ACOs reporting under the APP.

A Medicare CQM is a MIPS CQM reported by an ACO under the APP on only the ACO's eligible FFS beneficiaries that meet visit criteria,* instead of its all payer/all patient population.

- Quality ID #001SSP: -Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- Quality ID #134SSP: -Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- Quality ID #236SSP: -Controlling High Blood Pressure

To support ACOs in reporting Medicare CQMs for performance year 2024, CMS will provide each ACO with a list of beneficiaries eligible for Medicare CQMs (as defined at 42 CFR 425.20) updated each quarter throughout the performance year as part of the ACO's Quarterly Reports Package and delivered to ACOs via the data hub in the ACO Management System (ACO-MS).

*Visit criteria: claims encounters with ACO professionals with specialty designations used in the Shared Savings Program assignment methodology during the quality measurement period, or for patients who have designated an ACO professional participating in the ACO as responsible for coordinating their overall care.

Medicare Shared Savings Program

Medicare CQMs (cont.)

Quality Payment PROGRAM

The Quarterly List of Beneficiaries Eligible for Medicare CQMs will be cumulative and updated quarterly to reflect the most recent quarter's data. ACOs must apply measure specifications to the Quarter 4 (Q4) list of beneficiaries and use ACO system data for the full performance year for quality reporting. The Q4 list will include beneficiaries who are eligible for Medicare CQM reporting but may not meet denominator eligibility criteria for any measure. The anticipated delivery date for the Q4 data file will be around February 2025.

The Q4 reports will use the full 12 months of Medicare claims data to determine the value of the measure-specific variables indicating if a beneficiary had at least one measure eligible encounter, had a measure eligible diagnosis, and/or met a measure exclusion criteria for each of the Medicare CQMs.

ACOs can use the as a starting place for identifying and validating beneficiaries for Medicare CQM reporting and should confirm they have a complete and accurate universe of the beneficiaries eligible for each measure denominator for reporting.

Standards for data completeness, benchmarking, and scoring ACOs for the Medicare CQM collection type continues to align with MIPS policies.

ACOs that report Medicare CQMs will be eligible for the health equity adjustment to their quality performance score when calculating shared savings payments.

Medicare Shared Savings Program

Medicare CQMs: Posted Resources Available to ACOs

Quality Payment PROGRAM

These new resources are currently available to ACOs to aid in their understanding and future reporting of Medicare CQMs:

- **2024 Medicare CQMs Specifications:** Provides comprehensive descriptions of the 2024 Medicare CQMs used by Shared Savings Program ACOs for the MIPS quality performance category. 2024 Medicare CQMs Specifications and Supporting Documents for Accountable Care Organizations Participating in the Medicare Shared Savings Program

- **2024 Medicare CQMs Preparation and Implementation Checklist:** This resource provides steps that ACOs may take to prepare for and successfully complete quality reporting via the Medicare CQM collection type. 2024 Medicare CQMs for Shared Savings Program Accountable Care Organizations Checklist

- **PY 2024 Medicare CQM Data Dictionary and Report Template:** These resources provide an overview of Medicare CQMs and detail on the data elements included in the Medicare CQM beneficiary lists that will be included in quarterly reports starting May 2024. CMS has posted the PY 2024 Medicare CQM Data Dictionary and Report Template in the Templates section of the Program Resources resource type in the Knowledge Library tab in the ACO Management System (ACO-MS).

Medicare Shared Savings Program

Policies to Align CEHRT Requirements with MIPS

Quality Payment PROGRAM

To align the Shared Savings Program CEHRT requirements with MIPS, in the CY 2024 Medicare Physician Fee Schedule (PFS) final rule, we finalized to:

- **Sunset** the Shared Savings Program CEHRT threshold requirements beginning performance year 2025; and
- **Add** a new requirement, for performance years beginning on or after January 1, 2025, unless otherwise excluded, an ACO participant, ACO provider/supplier, and ACO professional that is a MIPS eligible clinician, QP, or Partial QP, regardless of track, must report the MIPS Promoting Interoperability performance category measures and requirements to MIPS and earn a performance category score at the individual, group, virtual group, or APM entity level.

For performance year 2025 and subsequent performance years, we will require that an ACO must publicly report the number of ACO participants, ACO providers/suppliers, and ACO professionals that are MIPS eligible clinicians, QPs, or Partial QPs that earn a performance category score for the MIPS Promoting Interoperability performance category. Certain exclusions will be allowed, including the following:

- Low volume threshold
- Eligible clinician who is not a MIPS eligible clinician
- Reweighting of the MIPS Promoting Interoperability performance category to zero percent of the final score in accordance with applicable policies.

Medicare Shared Savings Program

Other Major Policies for Revising the Quality Performance Standard

Quality Payment PROGRAM

Use of Historical Data to Establish the 40th Percentile MIPS Quality Performance Category Score

- For performance year 2024 and subsequent performance years, we will use a rolling, 3-performance year average with a lag of 1-performance year to calculate the 40th percentile MIPS Quality performance category score (e.g., the 40th percentile MIPS Quality performance category score used for the quality performance standard for performance year 2024 will be based on averaging the 40th percentile MIPS Quality performance category scores from performance years 2020 through 2022). Medicare Shared Savings Program Quality Performance Standard: 40th Percentile MIPS Quality Performance Category Score for Performance Year 2024 (PDF, 249 KB)

Apply a Shared Savings Program Scoring Policy for Excluded APP Measures and APP Measures that Lack a Benchmark

- For performance year 2024 and subsequent performance years, if an ACO reports all of the required measures under the APP, meets the data completeness requirement for each measure, and receives a MIPS Quality performance category score, we will use the higher of the ACO's health equity adjusted quality performance score or the 40th percentile MIPS Quality performance category score to determine whether the ACO meets the quality performance standard required to share in savings at the maximum rate under its track (or payment model within a track) when the ACO meets either of the following:
  - The ACO's total available measure achievement points used to calculate the ACO's MIPS Quality performance category score is reduced due to measure suppression, or
  - At least one of the eCQMs/MIPS CQMs/Medicare CQMs used in calculation of the MIPS Quality performance category score does not have a benchmark.

Quality Payment
PROGRAM

QCDR & Qualified Registry Overview & Timeline

Chris Ferrante, CMS

Anastasia Robben, MIPS QCDR/Registry Support Team (PIMMS Team)

What is a QCDR?

A QCDR is defined as an entity that demonstrates clinical expertise in medicine and quality measurement development that collects medical or clinical data on behalf of a CMS MIPS eligible clinician for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. A QCDR may include:

- An entity with clinical expertise in medicine. Clinicians are on staff with the organization and lend their clinical expertise in the work carried out by the organization as a QCDR.
- An entity with stand-alone quality measurement development expertise.
- An entity that uses an external organization for purposes of data collection, calculation, or transmission may meet the definition of a QCDR as long as the entity has a signed, written agreement that specifically details the responsibilities of the entity and the external organization. The written agreement must be effective as of September 1 of the year preceding the applicable performance period.[1]

Entities without clinical expertise in medicine and quality measure development that want to become a QCDR, may collaborate with entities with such expertise.

As an alternative to becoming a QCDR, entities may seek to qualify as another type of third party intermediary, such as a Qualified Registry. A Qualified Registry doesn't require quality measurement development experience.

A QCDR may self-nominate up to 30 quality measures not in the annual list of MIPS quality measures.[2] QCDRs will need to provide full QCDR measure specifications to CMS at the time of self-nomination.[3] CMS will review the quality measures and determine if they're appropriate for QCDR reporting.[4]

[1] § 414.1400(b)(3)(ii) [2] § 414.1400(b)(4)(iv)(P)
[3] § 414.1400(b)(4)(i)(B) [4] § 42 CFR 414.1400(b)(4)(iii)(C)

What is a Qualified Registry?

A Qualified Registry is a data intermediary that collects MIPS data from MIPS eligible clinicians and submits it to CMS on their behalf.[5]

- Clinicians work directly with their chosen Qualified Registry to submit data on the measures or activities they've selected.
- If the entity seeking to qualify as a Qualified Registry uses an external organization for purposes of data collection, calculation, or transmission, it must have a signed, written agreement with the external organization that specifically details the responsibilities of the entity and the external organization. The written agreement must be effective as of September 1 of the year preceding the applicable performance period.[6]
  - Qualified Registries may NOT support QCDR measures.

[5] § 414.1305
[6] § 414.1400(b)(3)(ii)

2024 MIPS Finalized Policies

Policies for Third Party Intermediaries:

Health Information Technology (IT) Vendors: Due to circumstances in which health IT vendors have submitted data that are inaccurate and unusable, and to ensure consistent requirements (such as data validation and auditing) across all third party intermediaries, we have finalized to eliminate the health IT vendor category beginning with the CY 2025 performance year.[7]

- Health IT vendors will still be able to participate in MIPS as third party intermediaries by self-nominating to become a QCDR or Qualified Registry (if applicable requirements are met). They can also continue to facilitate data submission by assisting clinicians with submitting their own data directly.

[7] § 414.1400(a)(1)(iii)

QCDR & Qualified Registry Requirements

As CMS approved QCDRs and Qualified Registries, you're required to:

- Comply with all requirements set forth by the 2024 Medicare Physician Fee Schedule (PFS) Final Rule and detailed within the 2024 Self-Nomination Fact Sheets (ZIP 4.3 MB).
- Support the quality, improvement activities, and Promoting Interoperability performance categories. [8]
  - QCDRs and Qualified Registries may be excepted from this requirement for Promoting Interoperability if its MIPS eligible clinicians, groups, and virtual groups are eligible for reweighting. [9]
- Support MVPs that are applicable to the MVP participant on whose behalf they submit MIPS data. QCDRs and qualified registries may also support the APP. A QCDR or qualified registry must support all measures and activities included in the MVP with the following exceptions[10]:
  - If an MVP is intended for reporting by multiple specialties, a QCDR or a qualified registry are required to report those measures pertinent to the specialty of its MIPS eligible clinicians.
  - Only the measure owner is required to report QCDR measures within an MVP.
  - Support subgroup reporting. [11]
- Support the performance categories, measures, and activities listed on the qualified posting for the entire MIPS performance period and corresponding submission period.
  - Withdrawal mid-performance period for any reason is unacceptable and will result in the termination of your organization as a third party intermediary.

[8] § 414.1400(b)(1)(i)
[9] § 414.1400(b)(1)(i)(B)
[10] § 414.1400(b)(1)(ii)
[11] § 414.1400(b)(1)(iii)

QCDR & Qualified Registry Requirements

- Have at least 25 participants by January 1 of the year prior to the applicable performance period (January 1, 2023, for consideration for the CY 2024 MIPS performance period).[12] These participants aren't required to use the QCDR or Qualified Registry to report MIPS data to CMS, but they must submit data to the intermediary for quality improvement.[13]
- Be up and running by January 1 of the performance period to accept and retain data, to allow clinicians to begin their data collection on January 1 of the performance period.[14] A system that isn't "live" beginning with the start of the performance period is considered non-compliant with this requirement.
- Submit data via a CMS-specified secure method for data submission, such as the QPP data format.[15] Additional information regarding data submission methodologies can be found in the Developer Tools on the QPP website.
    - Submit data on behalf of **all-payer data**, and not just Medicare Part B claims patients.[16]
    - Retain for the purposes of MIPS, all records or data, for 6 years from the end of the MIPS performance period.[17]
    - Comply with any CMS request to review your submitted data. For the purposes of auditing, CMS may request any records or data retained for the purposes of MIPS for up to 6 years from the end of the MIPS performance period.[18]
    - QCDRs and Qualified Registries must provide CMS access to review the Medicare beneficiary data on which 2024 MIPS submissions are based or provide to CMS a copy of the actual data (if requested for validation purposes).

[12] §42 CFR 414.1400(b)(3)(i)
[13] 81 FR 77383
[14] § 414.1400(b)(3)(xvii)
[15] § 414.1400(a)(3)(i)
[16] § 414.1400(a)(3)(ii)(A)
[17] § 414.1400(a)(3)(ii)(A)
[18] § 414.1400(a)(3)(v)(C)

QCDR & Qualified Registry Requirements

- Must enter into appropriate Business Associate Agreements with MIPS eligible clinicians and that they must maintain records of their authorization to submit data to CMS for the purpose of MIPS participation for each NPI whom they submit data to CMS for. The records must be annually obtained, be signed by an eligible clinician or by an authorized representative of the reporting group, and records of the authorization must be maintained for 6 years after the performance period ends. [19]
    - **Business Associate Agreement (BAA):** Obtain and keep on file signed documentation that each holder of an NPI has authorized the QCDR or Qualified Registry to submit quality measure results, improvement activities measure and activity results, Promoting Interoperability results and numerator and numerator and denominator data or patient-specific data on Medicare and non-Medicare beneficiaries to CMS for the purpose of MIPS participation. This documentation should be obtained at the time the clinician or group enters into an agreement with the QCDR or Qualified Registry to submit MIPS data to the QCDR or Qualified Registry and must meet the requirements of any applicable laws, regulations, and contractual business associate agreements. Groups participating in MIPS via a QCDR or Qualified Registry may have their group's duly authorized representative grant permission to the QCDR or Qualified Registry to submit their data to us. If submitting as a group, each individual clinician doesn't need to grant their individual permission to the QCDR or Qualified Registry to submit their data to us.
        - BAAs must comply with Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.
    - **Clinician Consent:** QCDRs and Qualified Registries must obtain signed documentation to indicate each client has authorized the QCDR or Qualified Registry to submit their data to CMS for the purpose of MIPS participation.

[19] § 414.1400(b)(3)(xii)

QCDR & Qualified Registry Requirements

Feedback Reports: QCDRs and Qualified Registries are required to provide performance category feedback on all performance categories supported at least 4 times a year and provide specific feedback to all clinicians, groups, virtual groups, and APM Entities including Shared Savings Program ACOs on how they compare to other clinicians, groups, virtual groups, and APM Entities including Shared Savings Program ACOs who have submitted data on a given measure and activity for traditional MIPS, MVPs, and the APP. [20]

- CMS doesn't provide a template for the performance feedback reports.
- If a real-time feedback dashboard is available to clinicians, CMS asks that the QCDR or Qualified Registry email clinicians, groups, virtual groups, and APM Entities including Shared Savings Program ACOs at least 4 times per year, to remind them that feedback is available.
- Exceptions to this requirement may occur if the QCDR or Qualified Registry doesn't receive the data from their clinician until the end of the performance period.

Certification Statement: QCDRs and Qualified Registries must certify that all data submissions to CMS on behalf of MIPS eligible clinicians, groups, virtual groups and APM Entities, inclusive of voluntary and opt-in participants are true, accurate, and complete to the best of your knowledge.[21] This certification applies to data submissions based on the acceptance of data exports directly from an electronic health record (EHR) or other data sources and for traditional MIPS, MVPs, and the APP. If you become aware that any submitted information isn't true, accurate, and complete, corrected information may be submitted until the end of the data submission period. If false, inaccurate, or incomplete data are identified after the data submission period, you should immediately notify CMS.

[20] § 414.1400(b)(3)(iii)
[21] § 414.1400(a)(3)

QCDR & Qualified Registry Requirements

Access to Data: CMS policy prohibits non-U.S. citizens from accessing CMS IT systems, and also requires all CMS program data to be retained in accordance with United States (U.S.) Federal policy, specifically National Institute of Standards and Technology (NIST) Special Publication (SP) 800–63, which outlines enrollment and identity proofing requirements (levels of assurance) for federal IT system access. Access to the QPP would necessitate passing a remote or in-person Federated Identity Proofing process (that is, Equifax or equivalent). A non-U.S. based third party intermediary's potential lack of a social security number, TIN, U.S. based address, and other elements required for identity proofing and identity verification would impact their ability to pass the necessary background checks. An inability to pass identity proofing may limit or fully deny access to the QPP if the intent is to interact with the QPP outside of the U.S. for the purposes of reporting and storing data. The CY 2019 Physician Fee Schedule Final Rule for the QPP amended this requirement to indicate that a third party intermediary's principal place of business and retention of associated CMS data must be within the U.S.[22]

[22] § 414.1400(a)(2)(i)(A)

QCDR & Qualified Registry Data Validation

During Self-Nomination, QCDRs and Qualified Registries submitted a data validation strategy for CMS review and approval that thoroughly explained the validation process of quality, improvement activity, and Promoting Interoperability data submitted to CMS.

QCDRs and Qualified Registries must conduct the data validation for the 2024 performance year prior to any data submission for the 2024 performance period. **The data validation must include all performance categories for which you will submit data and each submitter type for which you will submit data**, regardless of whether the clinicians or groups are MIPS eligible, voluntary participants, or are opting in.[23] You must use clinical documentation (provided by the clinicians they are submitting data for) to validate that the action or outcome measured actually occurred or was performed.[24]

The 2024 Data Validation Execution Report (DVER) with the results of your data validation audit must be submitted to CMS by June 2, 2025.[25]

- Late, incomplete, and/or absent submission of your DVER or the results for a required targeted audit constitutes non-compliance with program requirements and may result in remedial action or termination of the QCDR or Qualified Registry.
- A DVER Template will be posted on the QPP Resource Library.

[23] § 414.1400(b)(3)(v)(B) & (C)
[24] § 414.1400(b)(3)(v)(D)
[25] § 414.1400(b)(3)(v)(G)(1)

QCDR & Qualified Registry Training & Support Sessions

Quality Payment PROGRAM

- QCDRs or Qualified Registries must attend and complete training and support sessions in the form and manner, and at the times specified by CMS.[26]
  - Remedial action, up to and including termination as a third party intermediary may be imposed due to training and support session absences.
- For additional information regarding the training and support session schedule and requirements, please review the 2024 QCDR and Qualified Registry Training and Support Session Flyer that were previously distributed.

- The training and support session appointments will be distributed by QCDRVendorSupport@gdit.com and RegistryVendorSupport@gdit.com. Call materials, including agendas, minutes, timelines and any presentations, will be distributed via email from the same mailbox(es) the day prior and day of the call.
- The distribution list was developed with contacts from the 2024 self-nomination. If there are contacts that should be added that weren't included in the 2024 self-nomination or that should be removed, please submit a request to QCDRVendorSupport@gdit.com and RegistryVendorSupport@gdit.com.

[26] § 414.1400(a)(2)(iii)

QCDR & Qualified Registry Training & Support Sessions

Quality Payment PROGRAM

CMS will host a series of trainings that consist of an annual kickoff, monthly support calls, virtual office hours (VOHs), and public webinars and demonstrations.

- CMS will host monthly support calls for approved QCDRs and Qualified Registries. The monthly support calls will consist of program announcements, informational presentations and demonstrations addressing reporting requirements and steps for successful data submission. This meeting series also provides an opportunity to ask CMS subject matter experts technical questions related to MIPS reporting and data submission. Questions and feedback concerning CMS policy and non-technical questions will be referred to the QPP Service Center.
  - Participation in the monthly support calls is mandatory.
- CMS will host monthly VOHs for approved QCDRs and Qualified Registries. The VOHs offer QCDRs and Qualified Registries an opportunity to ask CMS subject matter experts questions related to the assigned topics for those calls. Only topic specific questions will be addressed during each call. All other questions will be referred to the QPP Service Center.
  - Participation in the VOHs isn't required but is strongly encouraged.
- CMS will host public webinars and demonstrations throughout the year to allow existing and prospective QCDRs and Qualified Registries the opportunity to attend the sessions.
  - Registration is required to attend the public webinars and demonstrations.
  - Participation to the public webinars and demonstrations may differ between calls and will be communicated as appropriate.

QCDR & Qualified Registry Training & Support Sessions

Quality Payment PROGRAM

- Each QCDR and Qualified Registry must have at least one representative in attendance on every mandatory call. Each intermediary must attend both the webinar via computer and audio portion via computer or phone to receive credit for attending the support call.
  - One attendee may count for one QCDR and one Qualified Registry if an organization operates under each entity type.
  - One attendee won't count for multiple QCDRs or multiple Qualified Registries.

- Mandatory call attendance will be tracked via Zoom for individuals attending the webinar. QCDRs and Qualified Registries must include your first name, last name and QCDR/Qualified Registry name on the Zoom registration screen. Please refrain from using names, abbreviations or acronyms for your organization or entity name that may not have been provided to CMS and MIPS QCDR/Registry Support Team (PIMMS Team).

QCDR & Qualified Registry Remedial Action & Termination

Quality Payment PROGRAM

CMS has the authority to impose remedial action or termination based on its determination that a third party intermediary is non-compliant with one or more applicable criteria for approval, has submitted a false certification, has submitted data that's inaccurate, unusable, or otherwise compromised,[27] not maintained current contact information for correspondence,[28] or are on remedial action for 2 consecutive years.[29]

QCDRs and Qualified Registries that have remedial action taken against them will be required to submit a corrective action plan (CAP) to address any deficiencies and detail any steps taken to prevent the deficiencies from reoccurring within a specified time period. The third party intermediary is required to submit a CAP via email by a date specified by CMS. The CAP must address the following issues unless different or additional information is specified by CMS:

- The issues that contributed to the non-compliance.
- The impact to individual clinicians, groups, virtual groups, or APM Entities including Shared Savings Program ACOs regardless of whether they're participating in the program because they're MIPS eligible, voluntarily participating, or opting in to participating in the MIPS program.
- The corrective actions implemented by the third party intermediary to ensure that the non-compliance issues have been resolved and won't recur in the future.
- The detailed timeline for achieving compliance with the applicable requirements.
- Develop a communication plan for communicating the impact to the parties identified in finalized § 414.1400(e)(1)(i)(B).[30] This would include individual clinicians, groups, virtual groups, subgroups, or APM Entities including Shared Savings Program ACOs, regardless of whether they're participating in the program because they're MIPS eligible, voluntarily participating, opting in to participate, and/or MVP participating in the MIPS program.
- Communicate the final resolution to CMS once the resolution is complete, and to provide an update, if any, to the monitoring plan provided.[31]

[27] § 414.1400(e)
[28] § 414.1400(e)(2)(iv)
[29] § 414.1400(e)(2)(v)
[30] § 414.1400(e)(1)(i)(B)
[31] § 414.1400(e)(1)(i)(F)

QCDR & Qualified Registry Remedial Action & Termination

Quality Payment PROGRAM

Failure to comply with the remedial action process may lead to termination of third party intermediaries for the current and/or subsequent performance year. If a third party intermediary is terminated, a transition plan must be submitted by a date specified by CMS. The transition plan must address the following unless different or additional information is specified by CMS:

- State the issues that contributed to the withdrawal mid-performance period or discontinuation of services mid-performance period.
- State the number of clinicians, groups, virtual groups, subgroups or APM Entities including Shared Savings Program ACOs inclusive of MIPS eligible, opt-in, and voluntary participants that would need to find another way to report and as applicable identify any QCDRs that were granted licenses to QCDR measures which would no longer be available for reporting due to the transition.
- State the steps the third party intermediary will take to ensure that the clinicians, groups, virtual groups, subgroups, or APM Entities including Shared Savings Program ACOs identified in § 414.1400(a)(3)(iv)(B)(1) are notified of the transition in a timely manner and successfully transitioned to an alternate third party intermediary, submitter type, or, for any measure or activity on which data has been collected, collection type, as applicable.
- Require that the transition plan include a detailed timeline of when the third party intermediary will take the steps identified in paragraph (a)(3)(iv)(C), including notification of affected clinicians, groups, virtual groups, subgroups, or APM Entities including Shared Savings Program ACOs, the start of the transition, and the completion of the transition.
- The third party intermediary must communicate to CMS that the transition was completed by the date included in the detailed timeline.[32]
- The 2024 QCDR and Qualified Registry Qualified Posting will be updated to reflect when remedial action has been taken and/or termination of third party intermediaries participating as a Qualified Registry.

[32] § 414.1400(a)(3)(iv)(A) - 414.1400(a)(3)(iv)(E)

QCDR & Qualified Registry Data Integrity

Quality Payment PROGRAM

CMS will further evaluate the QCDR or Qualified Registry to determine if any additional inaccurate, unusable or otherwise compromised data has been submitted.[33] Data inaccuracies may lead to remedial action/termination of the QCDR or Qualified Registry for future program year(s) based on CMS discretion.

CMS will evaluate data submitted for quality measures for data completeness and accuracy. The QCDR or Qualified Registry will also certify that all data submitted (including quality measures, improvement activities, and Promoting Interoperability objectives and measures) are true, accurate, and complete to the best of their knowledge.

CMS will determine error rates calculated on data submitted to CMS for clinicians, groups, virtual groups, and APM Entities including Shared Savings Program ACOs.

CMS will evaluate data inaccuracies including, but not limited to:

- TIN-NPI Issues – Incorrect TINs, incorrect NPIs, submission of group NPIs.
- Formatting Issues – Submitting files with incorrect file formats, submitting files with incorrect element formats, failure to update and resubmit rejected files.
- Calculation Issues – Incorrect qualities for measure elements, performance rates, and/or data completeness rates; numerators larger than denominators.
- Data Audit Discrepancies – Since data audits are required to occur prior to data submission, QCDRs and Qualified Registries should correct all identified errors prior to submitting the data to CMS. QCDR or Qualified Registry acknowledgement of data discrepancies found post submission from clinician feedback reports will be taken into consideration by CMS.

[33] § 414.1400(e)(1)

QCDR & Qualified Registry Timeline

The QCDR and Qualified Registry timeline will be distributed with the monthly support call materials and discussed on every monthly support call. The timelines included in this presentation are subject to change and will be included as updates in the monthly support call as needed.

CMS expects all QCDRs and Qualified Registries to understand the requirements and timeline milestones. CMS requires intermediaries to meet those requirements and timeline milestones to remain in good standing as a CMS approved 2024 QCDR or Qualified Registry.

QDCR & Qualified Registry Timeline	Start	Finish
Performance Period 2023		
Data Validation		
Submit Data Validation Execution Report (DVER)	1/2/2024	5/31/2024

QCDR & Qualified Registry Timeline

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QDCR & Qualified Registry Timeline	Start	Finish
Performance Period 2024		
Self-Nomination		
Add Additional MIPS Quality Measures	1/2/2024	5/3/2024
Data Validation		
Submit Data Validation Execution Report (DVER)	1/2/2025	6/2/2025

QCDR & Qualified Registry Timeline

Quality Payment PROGRAM

QDCR & Qualified Registry Timeline	Start	Finish
Clinician Information		
Verify & Maintain Signed Verification of Clinician Info	1/2/2024	3/31/2025
Verify & Maintain Business Agreements	1/2/2024	3/31/2025
Verify & Maintain Signed Clinician Consent	1/2/2024	3/31/2025
Data Submission		
Obtain and/or verify HARP Account	6/1/2024	10/1/2024
Developer Preview and Production Tokens Expire	11/30/2024	11/30/2024
Developer Preview and Production Tokens Refresh	12/1/2024	12/1/2024
Developer Preview*	9/1/2024	3/31/2025
Production Submission	1/2/2025	3/31/2025

QCDR & Qualified Registry Timeline

Quality Payment PROGRAM

QDCR & Qualified Registry Timeline	Start	Finish
Performance Feedback Reports		
Provide Feedback to Clinicians (at least 4 times a year)	1/1/2024	3/31/2025
CMS Sponsored Calls		
QCDR Measure Workgroup	2/8/2024	2/8/2024
2024 Self-Nomination, Data Validation, and QCDR Measure Submission Demonstration	6/20/2024	6/20/2024
2024 Self-Nomination, Data Validation, and QCDR Measure Submission Question and Answer Session	8/22/2024	8/22/2024

QCDR & Qualified Registry Timeline

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QDCR & Qualified Registry Timeline	Start	Finish
September Support Call	9/10/2024	9/10/2024
October Support Call	10/8/2024	10/8/2024
November Support Call	11/12/2024	11/12/2024
December Support Call	12/10/2024	12/10/2024
January Support Call	1/7/2025	1/7/2025
February Support Call	2/11/2025	2/11/2025
March Support Call	3/11/2025	3/11/2025
Virtual Office Hours		
July Virtual Office Hours: Self-Nomination and QCDR Measures	7/18/2024	7/18/2024

QCDR & Qualified Registry Timeline

Quality Payment PROGRAM

QDCR & Qualified Registry Timeline	Start	Finish
September Virtual Office Hours: Benchmarking, Scoring, and Tech Talk	9/10/2024	9/10/2024
October Virtual Office Hours: Tech Talk	10/8/2024	10/8/2024
November Virtual Office Hours: Data Validation Execution Reports	11/12/2024	11/12/2024
December Virtual Office Hours: Benchmarking, Scoring, and Tech Talk	12/10/2024	12/10/2024
January Virtual Office Hours: Tech Talk	1/7/2025	1/7/2025
February Virtual Office Hours: Tech Talk	2/11/2025	2/11/2025
March Virtual Office Hours: Tech Talk	3/11/2025	3/11/2025
Public Webinars and Demonstrations*		
July Virtual Office Hours: Self-Nomination and QCDR Measures	7/18/2024	7/18/2024

QCDR & Qualified Registry Timeline

Quality Payment PROGRAM

QDCR & Qualified Registry Timeline	Start	Finish
Performance Period 2025		
Self-Nomination		
Submit Self-Nomination	7/1/2024	9/3/2024
Submit MIPS Quality Measures, improvement activities, and Promoting Interoperability measures	7/1/2024	9/3/2024
Submit QCDR Measures for CMS Consideration *(QCDRs Only)*	7/1/2024	9/3/2024
QCDR Measures		
QCDR Measure Preview Calls *(QCDRs Only)**	2/12/2024	5/31/2024
Data Validation		
Submit Data Validation Strategy	7/1/2024	9/3/2024

*Last date to request a 2024 QCDR Measure Preview Call is 5/17/2024.

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PROGRAM

QCDR & Qualified Registry Feedback

QCDR & Qualified Registry Feedback

Swapnil Bhojane

Sr. MIPS Implementation Consultant
The Physicians Quality Registry (The PQR)

Questions?

Lunch

12 – 1 p.m. ET

Welcome

Attendance Tracking Information

Webinar Information

Quality Payment
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Doctors & Clinicians Public Reporting

Julie Johnson, CMS

Heather Litvinoff, Doctors & Clinicians Support Team

Doctors & Clinicians Public Reporting

The Doctors & Clinicians section of Care Compare replaced Physician Compare profile pages and the Provider Data Catalog (PDC) replaced the Downloadable Database in December 2020.

QPP performance information (2022 performance year data) will be made available for public reporting on the Doctors & Clinicians section of Care Compare following targeted reviews.

All doctor and clinician performance information on Care Compare and in the PDC must meet the established public reporting standards, except as otherwise required by statute (§ 414.1395(b)).

- To be included in the PDC, performance information must be statistically valid, reliable, and accurate; be comparable across collection types; and meet the minimum reliability threshold.
- To be included on Care Compare profile pages, performance information must also resonate with Medicare patients and caregivers, as determined by user testing.

Additionally, quality and cost measures in their first two years of use will not be publicly reported (§ 414.1395(c))

Doctors & Clinicians Public Reporting

The following 2022 MIPS performance information is available for public reporting* for clinicians and groups:

- Quality (MIPS, CAHPS for MIPS, and QCDR measures)
- Improvement activities
- Promoting Interoperability measures and attestations
- Cost measures
- MIPS final score and performance category scores

Aggregate performance information will be publicly available in the PDC and updated periodically

*Although all performance information is considered "available for public reporting," not all performance information will be publicly reported. The Doctors and Clinicians support team will share more information about what will be publicly reported as it becomes available.

2024 MIPS Finalized Policies

Public Reporting

Utilization Data

- Modifying existing policy about publicly reporting procedure utilization data on individual clinician profile pages by incorporating Medicare Advantage data with Medicare Fee-for-Service data for a more accurate representation of procedure volumes among Medicare beneficiaries.

Telehealth Indicators

- Instead of using specific Place of Service (POS) and claims modifier codes to identify telehealth services through annual rulemaking, we'll use the most recent POS and claims modifier codes available as of the time the information is refreshed on clinician profile pages. This will give us more flexibility to ensure the accuracy of the telehealth indicator and reduce annual regulatory burden.

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Quality Measures Overview

Colleen Jeffrey, MIPS Quality Team & QCDR/Registry Support Team (PIMMS Team)

CMS Strategic Vision

The CMS National Quality Strategy: Meaningful Measures 2.0 and the Cascade of Meaningful Measures Framework:

Sets and raises the bar for a resilient, high-value health care system that promotes quality outcomes, safety, equity, and accessibility for all individuals, especially for people in historically underserved and under-resourced communities.

Promotes innovation and modernization of all aspects of quality, addressing a wide variety of settings, interested parties, and measurement requirements.

Represents an approach to measures, which will reduce the collection and reporting burden, while producing measurement focused on meaningful outcomes important to patients.

Identifies the highest priorities for quality measurement and improvement.

Serves as a guide for CMS when evaluating each measure for potential inclusion on the Measures Under Consideration (MUC) List to ensure that the selection of measures pursues and aligns with the agency's priorities.

Helps prioritize existing health care quality measures, align or reduce measures where there are too many, and identify gaps where new measures may need to be developed.

What are Quality Measures?

Quality measures are tools that help us to:

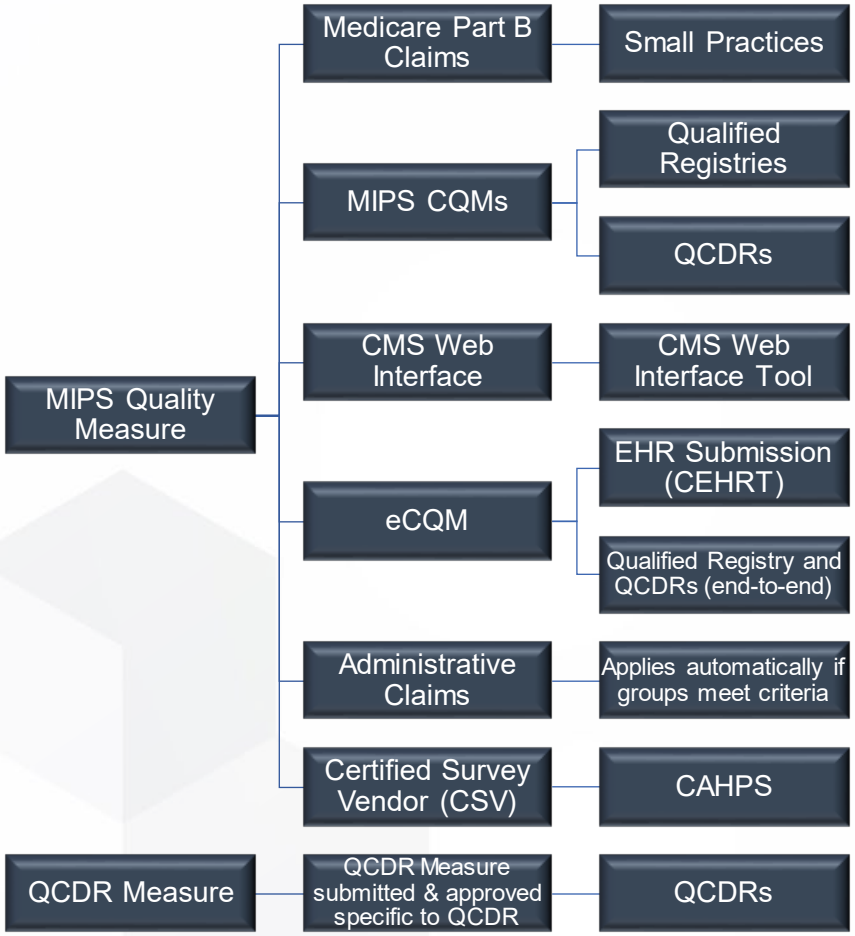
- Measure health care processes, outcomes, and patient experiences.
- Link outcomes that relate to one or more of these quality goals for health care that's effective, safe, efficient, patient-centered, equitable, and timely.

QCDRs may support any combination of MIPS CQMs, eCQMs, and approved QCDR measures.

- Please note that only QCDRs support QCDR measures (with stewardship or permission obtained).

Qualified Registries may support any combination of MIPS CQMs and eCQMs.

QCDRs and Qualified Registries can also support MVPs.



Classifications

High Priority – Measures that address a specific national health goal or priority; affects large numbers of patients; is a leading cause of morbidity/mortality; high resource use and severity of patient/societal consequences of poor quality. For Patient-Reported Outcome-Based Performance Measure (PRO-PMs), there is evidence that the target population values the PRO-PM and finds it meaningful.

These include the following categories:

- Outcome (including Intermediate Outcome and Patient-Reported Outcome)
- Patient Experience
- Patient Safety
- Efficiency
- Appropriate use
- Care Coordination
- Opioid-related
- Equity

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High Priority MIPS CQM Example:

- Quality ID #398: Optimal Asthma Control

Classifications

Outcome – An outcome measure is a measure that focuses on the health status of a patient (or change in health status) resulting from healthcare—desirable or adverse.

Patient Engagement/Experience – Aims to improve the patient experience such as improving CMS customer experience, supporting innovative approaches to improve quality, accessibility, and affordability, and most importantly empowering patients and clinicians to make decisions about their healthcare.

Patient-Reported Outcome-Based Performance Measure – A PRO-PM measure is a performance measure that is based on patient-reported outcome measure (PROM) data aggregated for an accountable healthcare entity. The data are collected directly from the patient using the PROM tool, which can be an instrument, scale, or single-item measure.

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Outcome MIPS CQM Example:

- Quality ID #191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

Patient Engagement/Experience MIPS CQM Example:

- Quality ID #304: Cataracts: Patient Satisfaction within 90 Days Following Cataract

PRO-PM MIPS CQM Example:

- Quality ID #471: Functional Status After Lumbar Surgery

Classifications

Intermediate Outcome – An intermediate outcome measure is a measure that assesses the change produced by a healthcare intervention that leads to a long-term outcome.

- Non-outcome measure closely linked to an outcome of interest.

Proportion: A score derived by dividing the number of cases that meet a criterion for quality (the numerator) by the number of eligible cases within a given time frame (the denominator) where the numerator cases are a subset of the denominator cases (e.g., percentage of eligible women with a mammogram performed in the last year).

- The performance rate of a proportion measure is defined as the number of patients meeting the quality action, divided by the denominator eligible population.

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Intermediate Outcome MIPS CQM Example:

- Quality ID #236: Controlling High Blood Pressure

Proportion MIPS CQM Example:

- Quality ID #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Classifications

Continuous Variable: A measure score in which each individual value for the measure can fall anywhere along a continuous scale (e.g., mean time to thrombolytics, which aggregates the time in minutes from a case presenting with chest pain to the time of administration of thrombolytics).

- Aggregate scores for continuous variable measures are more complex than for proportion measures in that they are more than just the counts of individuals in each population.

Ratio: A score that may have a value of zero or greater that is derived by dividing a count of one type of data by a count of another type of data. The key to the definition of a ratio is that the numerator isn't in the denominator (e.g., the number of patients with central lines who develop infection divided by the number of central line days).

- Rates closer to 1 represent the expected outcome.
- **Example**: Actual/Expected

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Continuous Variable MIPS CQM Example:

- Quality ID #483: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

Definitions

Numerator Data: The upper portion of a fraction used to calculate a rate, proportion, or ratio.

- The numerator must detail the quality clinical action expected that satisfies the condition(s) and is the focus of the measurement for each patient, procedure, or other unit of measurement established by the denominator (that is, patients who received a particular service or clinicians that completed a specific outcome/process).

Denominator Data: The lower portion of a fraction used to calculate a rate, proportion, or ratio.

- The denominator must describe the population eligible (or episodes of care) to be evaluated by the measure. This should indicate age, condition, setting, and timeframe (when applicable). For example, "Patients aged 18 through 75 years with a diagnosis of diabetes."

Definitions

Denominator Exceptions: Applies when a patient is eligible for the denominator, but the measure specifications define circumstances in which a patient may be appropriately deemed as a denominator exception. This permits the exercise of clinical judgment and implies that the treatment was at least considered for each eligible patient such as medical, patient or system reason.

Denominator Exclusions: Refers to criteria that remove the encounter/patient from the denominator before determining if the quality action was completed. Exclusions are more absolute where the quality action isn't applicable and wouldn't be considered for a population.

Numerator Exclusions: Applies to ratio measures to define instances that shouldn't be included in the numerator data.

- **Ratio:** If the number of central line blood stream infections per 1000 catheter days were to exclude infections with a specific bacterium, that bacterium would be listed as a numerator exclusion.

Definitions

Inverse Measures: A lower calculated performance rate for this type of measure would indicate better clinical care, or control.

- The "Performance Not Met" numerator option for an inverse measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases.

Multi Strata Measures: Multiple denominator options to reduce the number of measures addressing a similar condition, quality action, or topic.

- Reasons for stratification: age groupings, specific condition, specific location, different complications of the same procedure, vaccinations, etc.

Composite Measures: A combination of 2 or more individual performance measures that results in a single score.

- Composite measures can provide a broader assessment of quality care.

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Inverse MIPS CQM Example:

- Quality ID #001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

Multi Strata MIPS CQM Example:

- Quality ID #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Composite MIPS CQM Example:

- Quality ID #497: Preventive Care and Wellness (Composite)

Submission Frequency

Patient-Intermediate measures are submitted a minimum of once per patient during the performance period. The most recent quality-data code will be used, if the measure is submitted more than once.

Patient-Process measures are submitted a minimum of once per patient during the performance period. The most advantageous quality-data code will be used if the measure is submitted more than once.

Patient-Periodic measures are submitted a minimum of once per patient per timeframe specified by the measure during the performance period. If more than 1 quality-data code is submitted during the episode time period, performance rates shall be calculated by the most advantageous quality-data code.

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Patient-Intermediate MIPS CQM Example:

- Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Patient-Process MIPS CQM Example:

- Quality ID #039: Screening for Osteoporosis for Women Aged 65-85 Years of Age

Patient-Periodic MIPS CQM Example:

- Quality ID #409: Clinical Outcome Post Endovascular Stroke Treatment

Submission Frequency

Episode measures are submitted once for each eligible occurrence of a particular illness or condition during the performance period.

Procedure measures are submitted each time an eligible procedure is performed during the performance period.

Visit measures are submitted each eligible encounter when a patient is seen by the individual MIPS eligible clinician during the performance period.

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Episode MIPS CQM Example:

- Quality ID #217: Functional Status Change for Patients with Knee Impairments

Procedure MIPS CQM Example:

- Quality ID #167: Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure

Visit MIPS CQM Example:

- Quality ID #130: Documentation of Current Medications in the Medical Record

MIPS CQM Specification & Flow Demonstration

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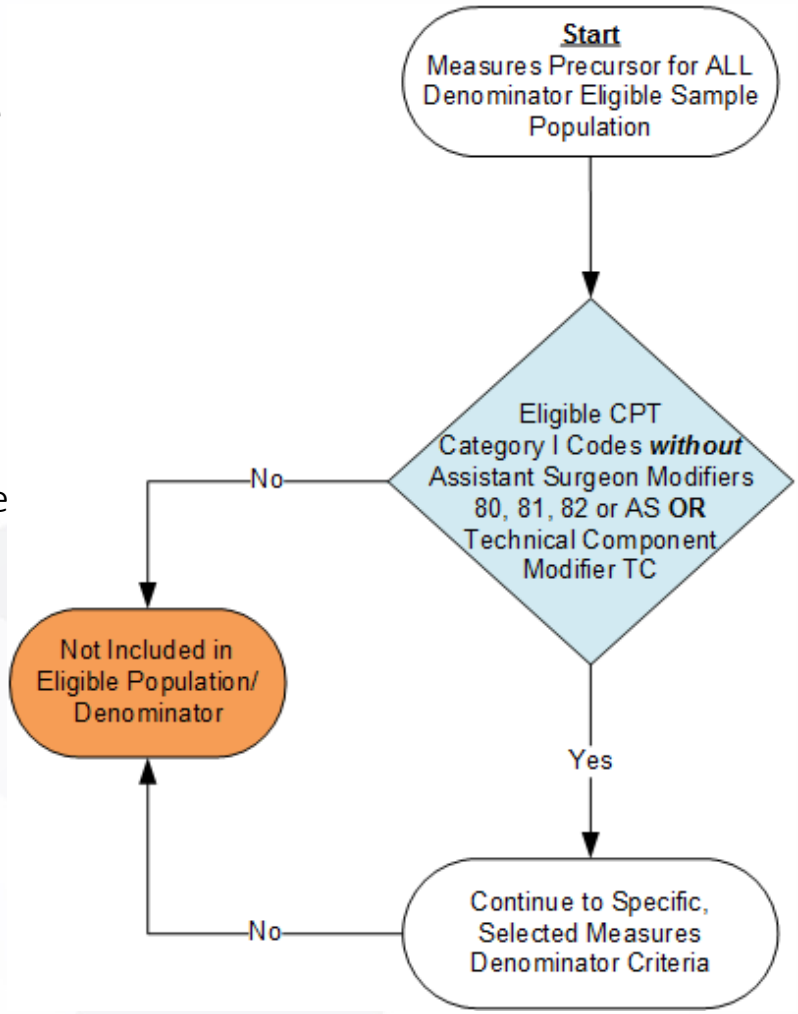
MIPS CQM example: Quality ID #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Sample Flow

MIPS CQM Flows are designed to provide visual interpretation of the measure logic and calculation methodology for data completeness and performance rates. The flows start with the identification of the patient population (denominator) for the applicable measure's quality action (numerator). When determining the denominator for all measures, please remember to **include patients from all payers** and CPT Categories **without** modifiers 80, 81, 82, AS or TC.

On the right is an illustration of additional prerequisite denominator criteria to obtain the patient sample for **all** 2023 MIPS quality measures.



Data Completeness Rate

Data Completeness is a MIPS requirement that ensures eligible clinicians are reporting numerator options on **75% or more** of all their denominator eligible patients for each measure submitted. Data completeness for a measure may include the following categories provided in the numerator:

- Performance Met
- Denominator Exception, if applicable
- Performance Not Met

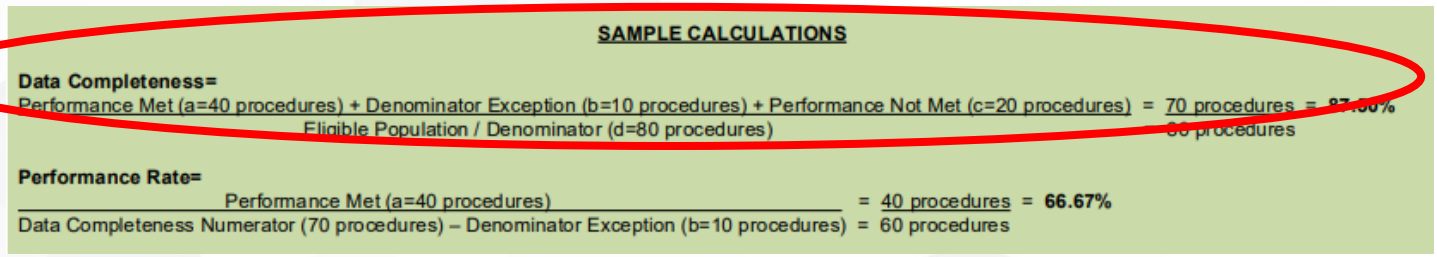
The Data Completeness Algorithm calculation is based on the eligible population and sample outcomes of the possible quality actions as described in the flow of the measure. The Data Completeness Algorithm provides the calculation logic for patients who have been submitted in the MIPS eligible clinicians' appropriate denominator. Data completeness for a measure may include the following categories provided in the numerator: Performance Met, Denominator Exception, and Performance Not Met.

How does Data Completeness operate within the collection types?

- For the Medicare Part B claims collection type, all claims reported by the clinician will be analyzed for denominator eligibility and inclusion of a Quality Data Code (QDC) on the Medicare Part B Claims.
- For MIPS clinical quality measures (CQMs) collection type, numerator options abstracted from available data sources would be reported within the clinician's/group's submission.

Data Completeness Rate

- What is Data Completeness for the MIPS program?
  - Data Completeness is a MIPS requirement that ensures eligible clinicians are reporting numerator options on **75% or more** of all their denominator eligible patients for each measure submitted.



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 procedures) + Denominator Exception (b=10 procedures) + Performance Not Met (c=20 procedures) = 70 procedures = **87.50%**
Eligible Population / Denominator (d=80 procedures) 80 procedures

Performance Rate=

Performance Met (a=40 procedures) = 40 procedures = **66.67%**
Data Completeness Numerator (70 procedures) – Denominator Exception (b=10 procedures) = 60 procedures

- How does Data Completeness operate within the collection types?
  - For the Medicare Part B claims collection type, all claims reported by the clinician will be analyzed for denominator eligibility and inclusion of a Quality Data Code (QDC) on the Medicare Part B Claims.
  - For MIPS clinical quality measures (CQMs) collection type, numerator options abstracted from available data sources would be reported within the clinician's/group's submission.
- How do the Components of the Quality Measure Translate to the Calculation of Data Completeness?
  - The data completeness numerator or total number of patients that had a numerator option reported divided by the total number denominator eligible patients identified, for the measure.

Performance Rate

For those patients included in the **Data Completeness numerator (minus denominator exceptions)**, the numerator of the performance rate is determined by completing the quality action as indicated by **Performance Met.**

SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 procedures) + Denominator Exception (b=10 procedures) + Performance Not Met (c=20 procedures) = 70 procedures = **87.50%**
Eligible Population / Denominator (d=80 procedures) = 80 procedures

Performance Rate=

Performance Met (a=40 procedures) = 40 procedures = **66.67%**
Data Completeness Numerator (70 procedures) – Denominator Exception (b=10 procedures) = 60 procedures

For measures with inverse performance rates, such as Measure #001 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control, a lower rate indicates better performance. Submitting the Performance Not Met is actually the clinically recommended outcome or quality action.

Additional Resources

Additional resources, including the below, are located in the 2024 MIPS Clinical Quality Measure Specifications and Supporting Documents (ZIP 58MB)

Single Source: Excel document for both the Medicare Part B Claims and MIPS CQM collection types that contains all coding elements for -each measure specification.

- **Release Notes:** Outlines the changes implemented from the previous performance period.
- **Measure Specification and Measure Flow Guide:** Provides general guidance and definitions regarding quality measures and flows.

Quality Scoring Flexibilities

The following list of reasons could impact a quality measure during the performance period:

- Errors found in the finalized measure specifications.
  - These errors include, but are not limited to:
    - Changes to the active status of codes.
    - The inadvertent omission of codes.
    - The inclusion of inactive or inaccurate codes.
- Updates to ICD-10 codes during the performance period.
  - We publish a list of measures requiring 9 consecutive months of data to be reported on the QPP Resource Library by October 1st of the performance period (if technically feasible), but no later than the beginning of the data submission period (for example, January 2, 2025, for the 2024 performance period).
  - Clinical guideline changes.
- Updates to measure specifications during the performance period.

For a quality measure impacted by one of the above items, the quality measure will have a truncated performance period of 9 consecutive months if there are 9 consecutive months of accurate, available data.

If there aren't 9 consecutive months of available data and revised clinical guidelines, measure specifications or codes impact a clinician's ability to submit information on the measure, the measure will be suppressed.

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Roles & Access in QPP

Steven Szeliga, Product Team

Roles & Access in QPP

Users who wish to view feedback within QPP and submit data via the user interface must have a user **profile** and **roles** against each organization.

As a new QPP user, you can establish your profile by going to QPP.cms.gov/login and selecting Register.

Additional information regarding roles and access can be found in the QPP Access User Guide.

Roles & Access in QPP

Users who wish to view feedback within QPP and submit data via the user interface for ACO's must have a user **profile** and **roles** against each organization.

As a new ACO user, you can establish your profile by going to https://acoms.cms.gov/ and selecting Register.

This role will then be used to log in to QPP.

Commonly Used Terms

Profile: Every QPP user must set up a profile, which consists of your name, contact information, a username and password, and Multi-factor authentication (MFA). Profiles are verified using Remote Identity Proofing. Profiles are managed in Health Care Quality Information Systems (HCQIS) Access Roles and Profile (HARP).

Role: Once a user has established a profile and signed in, they can request roles against QPP Organizations. Currently, QPP allows practices, APMs, QCDRs, Qualified Registries, and virtual groups to submit data and view feedback. Users can request a security official role or a staff user role.

MFA: To sign into QPP, users must have a secondary form of authentication (the first is username/password). Currently accepted MFA devices are text message, phone number, Google Authenticator, and Okta Verify.

HARP: HARP is the name of the service that provides profile set up and management for QPP.

API Token: A special token is provided to approved QCDRs and Qualified Registries to submit data on behalf of any participant in QPP via the application programming interface (API).

Role Management

	Report Data Including participation status, reporting data, and performance feedback	**Manage Users** Add and remove other users to the organization.
Staff User	✓	✗
Security Official	✓	✓

For registries, only **security officials** can download and refresh API tokens.

If you are the **first** security official for a registry, you will need to provide the QCDR and Qualified Registry's name, TIN, and CMS Entity ID. All subsequent role requests will be sent to the established security official(s).

API Token

API tokens allow registries to submit data directly through the API on behalf of any TIN they represent.

API tokens expire on November 30th of each calendar year.

Users can manually refresh their tokens.

QCDRs and Qualified Registries new to QPP in 2023 will receive further instruction in monthly Tech Talks.

QCDR Measure Submission

- The Intermediary ID will be utilized to determine those approved to submit each QCDR measure
- If you report a QCDR measure that you are not authorized to submit, you will receive the following error messages:
    - Registry Token or Role: “Only approved QCDRs are allowed to submit data for QCDR Measures.”
    - QCDR Token or Role: “Intermediary ID {id attached to submission} does not have access to submit {measure id}. Please contact the QCDR and Qualified Registry support group if this is incorrect.”

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Tech Talk

Steven Szeliga, Product Team

Submission Overview

Clinicians, groups and virtual groups work directly with a QCDR or Qualified Registry to submit data for quality, Promoting Interoperability, and improvement activities using the below formats.

Performance Category	Data Formats
Quality	– QPP JavaScript Object Notation (JSON) – Quality Reporting Data Architecture (QRDA) III eXtensible Markup Language (XML) (eCQMs only)
Promoting Interoperability	– QPP JSON – QRDA III XML
Improvement Activities	– QPP JSON – QRDA III XML

Universal Submission Methods

	Promoting Interoperability	Improvement Activities	Quality
Upload file on QPP website	QPP JSON QRDA III	QPP JSON QRDA III	QPP JSON QRDA III (eCQMs only)
Manual attestation on QPP website	Y	Y	N
Submissions API	QPP JSON QRDA III	QPP JSON QRDA III	QPP JSON QRDA III (eCQMs only)
Quality code on claim	N	N	Y
CMS Web Interface	N	N	Y

QCDR & Qualified Registry Submission Methods

	Promoting Interoperability	Improvement Activities	Quality
Upload file on QPP website	QPP JSON QRDA III	QPP JSON QRDA III	QPP JSON QRDA III (eCQMs only)
Manual attestation on QPP website	N	N	N
Submissions API	QPP JSON QRDA III	QPP JSON QRDA III	QPP JSON QRDA III (eCQMs only)
Quality code on claim	N	N	Y
CMS Web Interface	N	N	Y

Submission Resources

Developer Tools Page on QPP Website

- https://QPP.cms.gov/developers
- Overview of the APIs and links to all other support resources.

API and QPP Data Format Specifications

- https://cmsgov.github.io/qpp-submissions-docs/

API and QPP Guides

- https://cmsgov.github.io/qpp-developer-preview-docs/

Developer Sandbox

- https://preview.qpp.cms.gov/api/submissions/public/docs/
- Developers can test integrating the APIs with their software and data.

QPP

- Developers who are unable to find answers using the above material, or who have policy questions, should bring questions to the monthly support calls/Virtual Office Hours, or contact the QPP at QPP@cms.hhs.gov.

Submission Timeline

Spring/Summer 2024

- Internal API Development

Fall 2024

- Developer Preview Environment Opens to Performance Year 2024
- Create test submissions with 2024 quality measures
- Preview scores based on 2024 scoring rules

January 2, 2025

- Submit official data to QPP via the production API
- QPP Submissions window opens for Performance Year 2024

Spring 2025

- QPP Submissions window closes March 31, 2025, at 8 p.m. ET for Performance Year 2024
- Use production API to retrieve previously submitted data.

Non-Proportional QCDR Measure Submission

As a reference, when submitting to the QPP, you should submit information for the following fields.

"measureId": *enter the measure ID here*,
"value": {
"isEndToEndReported": *boolean – writable - optional*,
"numerator": *float – writable - required*,
"denominator": *float – writable - required*,
"denominatorException": *float – writable - optional*,
"numeratorExclusion": *float – writable - optional*,
"observationInstances":*– integer – writable - required*,
"reportingRate": *– The API will calculate this.* }

This information will be updated in the Developer Documentation: https://cmsgov.github.io/qpp-submissions-docs/measurements. This documentation will reflect the entire metric type object as returned by the Application Programming Interface (API), including which fields are required, optional, and writable (that is calculated by the API or must be submitted to the API).

API Demonstration

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Scoring Overview

Steven Szeliga, Product Team

Scoring Overview

Basics for Performance Year 2024

75-point performance threshold

- This is the minimum number of points needed to avoid a negative payment adjustment; a final score of 75 points earns a neutral payment adjustment.

We'll compare a clinician's final score to the performance threshold to determine their payment adjustment.

MIPS eligible clinicians with a final score below 75 points will earn a negative payment adjustment between -9% and 0%, MIPS eligible clinicians with a final score above 75 points will earn a positive payment adjustment greater than 0%.

- Please note that this is a budget neutral program.
- To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a "scaling factor."
- The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.

Scoring Overview

Individual, Group, Subgroup*, and Virtual Group** Participation

Traditional MIPS and MVP Performance Category Weights in 2024:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
30% of MIPS Score	30% of MIPS Score	15% of MIPS Score	25% of MIPS Score

*Available for MVP reporting only.
**Available for Traditional MIPS reporting only.

Scoring Overview

APM Entity Participation

Traditional MIPS and MVP Performance Category Weights in 2024:

Scoring Overview

Standard Weighting for Small Practices

(Promoting Interoperability Automatically Reweighted to 0%)

Traditional MIPS and MVP Performance Category Weights in 2024:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
40% of MIPS Score	30% of MIPS Score	30% of MIPS Score	0% of MIPS Score

Scoring Overview

Quality measures submitted for the 2024 performance period will receive **between 0 and 10** measure achievement points.

Quality measures fall into one of three categories for scoring:

- The measure meets the data completeness criteria, has a benchmark, and the volume of cases is sufficient (>20 cases for most measures)
  - These measures continue to receive between **1 to 10 points** based on performance compared to the benchmark
- The measure meets the data completeness criteria but either (1) doesn't have a benchmark and/or (2) the volume of cases you've submitted is insufficient (<20 cases for most measures)
  - These measures continue to receive 0 points, **except** for small practices, which would continue to receive 3 measure achievement points*
- The measure doesn't meet the data completeness criteria
  - These measures continue to receive 0 points, **except** for small practices, which would continue to receive 3 measure achievement points*

** These measure achievement points scoring policies would not apply to CMS Web Interface measures and administrative claims-based measures.*

Scoring Overview

Class 4 Measures:

- The measure meets the data completeness criteria, the volume of cases is sufficient but does not have a benchmark
  - Newly introduced measures in their first year of the program will receive a score of 7 points
    - If a performance year benchmark can be established a score of 7 – 10 will be awarded (floor of 7 points)
  - Second year measures will receive a score of 5 points
    - If a performance year benchmark can be established a score of 5 – 10 will be awarded (floor of 5 points)*

** These measure achievement points scoring policies would not apply to CMS Web Interface measures and administrative claims-based measures.*

Benchmarks Overview

How are the benchmarks established?

When you submit measures for MIPS, each one is assessed against a benchmark to determine how many points the measure earns.

We establish quality performance benchmarks either:

- Prior to the reporting period for which they apply (*historical benchmarks* based off data from two years prior); or
- From data submitted for that performance period

Benchmarks Overview

How are benchmarks converted to points?

Each measure you submit is assessed against its collection-type specific benchmark to see how many points are earned based on your quality performance.

Each quality measure is scored on a **10-point** scale:

- Except for certain topped-out MIPS quality measures with a 7-point cap,
- Measures that don't meet data completeness criteria, and
- Measures that either don't have a benchmark and/or the volume of cases you've submitted is insufficient.

Performance is broken down into "deciles," with each decile corresponding to a value between 1 and 10 points.

There is a 1-point floor for measures that can be reliably scored based on performance for the 2024 MIPS performance period. As a result, measures in the lowest deciles cannot get less than 1 measure achievement points.

We compare your performance on a quality measure to the performance levels in the national performance (benchmarks).

The points you earn are based on the decile range that matches your performance level.

Bonus Points

Small Practice Bonus in 2024 performance year:

Small practice bonus will continue in the 2024 for the quality performance category,

6 bonus points will be 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.

Quality Improvement Bonus in 2024 performance year:

You can earn up to 10 percentage points based on the rate of your improvement in the quality performance category from the year before.

Improvement Scoring

How do we evaluate eligibility for improvement scoring?

You'll be evaluated for improvement scoring in 2024 when you:

Participate fully in the quality performance category for the current performance period:

- Submit 6 measures/specialty measures with at least 1 outcome/high priority measure OR
- Submit as many measures as were available and applicable; all measures must meet data completeness requirements

AND

- Have a quality performance category achievement percent score based on reported measures for the previous performance period (2023)

AND

- Submit data under the same identifier for the 2 performance periods, or if we can compare the data submitted for the 2 performance periods.

Improvement Scoring

Improvement scoring is calculated by comparing the quality performance category achievement percent score from the previous period to the quality performance category achievement percent score in the current period.

Measure bonus points are not included in improvement scoring.

Facility-based Measurement

In the 2024 MIPS performance period, we will identify clinicians and groups eligible for facility-based scoring.

These clinicians and groups may have the option to use facility-based measurement scores for their quality and cost performance category scores.

Facility-based measurement scoring will be used for your quality and cost performance category scores when:

- You are identified as facility-based; and
- You are attributed to a facility with a Hospital Value-Based Purchasing (VBP) Program score for the 2024 performance period; and
- The Hospital VBP score results in a higher score than MIPS quality measure data you submit and MIPS Cost measure data we calculate for you.

Facility-based Measurement

What is it?

Facility-based scoring is an option for clinicians that meet certain criteria beginning with the 2024 MIPS performance period:

- Facility-based scoring allows for certain clinicians to have their quality and cost performance category scores based on the performance of the hospitals at which they work.

Facility-based Measurement

Applicability: Individual

- MIPS eligible clinician furnishes 75% or more of their covered professional services in inpatient hospital (Place of Service code 21), on-campus outpatient hospital (POS 22), or an emergency room (POS 23), based on claims for a period prior to the performance period.

- Clinician would be required to have at least a single service billed with POS code used for inpatient hospital or emergency room.

Applicability: Group

- Facility-based group would be one in which 75% or more of eligible clinicians billing under the group's TIN are eligible for facility-based measurement as individuals.

Facility-based Measurement

Attribution

- Facility-based clinician would be attributed to hospital where they provide services to most patients.
- Facility-based group would be attributed to hospital where most facility-based clinicians are attributed.
- If unable to identify facility with the Hospital VBP score to attribute clinician's performance, that clinician would not be eligible for facility-based measurement and would have to participate in MIPS via other methods.

Election

- Automatically apply facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who would benefit by having a higher combined quality and cost score.
- No submission requirements for eligible individual clinicians for facility-based scoring, but a group would need to submit data for the improvement activities or Promoting Interoperability performance categories in order to be scored as a facility-based group.

Facility-based Measurement

Assigning MIPS Category Scores

- The quality and cost performance category scores (which are separate scores) for facility-based clinicians are based on how well the clinician's hospital performs in comparison to other hospitals in the Hospital VBP Program.

Scoring – Special Rules

- Some hospitals do not receive a Total Performance Score in a given year in the Hospital VBP Program, whether due to insufficient quality measure data, failure to meet requirements under the Hospital In-patient Quality Reporting (IQR) Program, or other reasons.
- In these cases, we would be unable to calculate a facility-based score based on the hospital's performance, and facility-based clinicians would be required to participate in MIPS via another method.

Facility-based Measurement

Assigning MIPS Total Score

- The quality and cost performance category scores (which are separate scores) for MIPS scoring is based on Quality performance scores and the applicability of Cost category.

Assigning Facility Total Score

- The quality and cost performance category scores (which are separate scores) will always be evaluated based on Facility performance and MIPS weighting.

Scenario	Quality Points/available points	Cost points/available points	Improvement Activities points/available points	Promoting Interoperability points/ available points	Final Score
Facility-based	26/30	27/30	15/15	20/25	88/100
Not facility-based	52/55	0/0	15/15	24/30	91/100

Eligible Measure Applicability (EMA)

What's the Eligible Measure Applicability (EMA) process?

CMS uses the EMA process to see if there are clinically related measures clinicians could have been submitted as part of traditional MIPS reporting. The EMA process doesn't apply to MVP or APP reporting.

- When is EMA applied?
  - EMA uses a clinical relations test to see if a clinician could have submitted more measures, including outcome and high priority measures.
  - EMA adjusts the scoring to accurately reflect how the clinical relations test affected the clinician's performance.
- Which data collection types are used with EMA?
  - Applicable: Part B Claims measures & MIPS CQMs
  - Not Applicable: eCQMs, QCDR measures, & Web Interface

Eligible Measure Applicability (EMA)

EMA Process Checks

- Was an outcome measure submitted if one was available?
- Was a high priority measure submitted if one was available?
- Were fewer than 6 measures submitted when at least 6 were available?

EMA Process Outcomes

- If EMA determines applicable measure was available, missing measure is scored with a performance of zero.
- If EMA determines no applicable measure was available, the missing measures are removed from the denominator and score is based on remaining measures.

Quality Payment
PROGRAM

Resources & Who to Contact for Assistance

Hector Cariello, MIPS QCDR/Registry Support Team (PIMMS Team)

Key Websites

QPP Website

QPP Participation Status Look-up Tool

MIPS Explore Measures & Activities Tool

QPP Resource Library

QPP Webinar Library

QPP Help and Support Page

QPP Listserv – available on the QPP website

Subscribe to Updates | Enter Email Address | Subscribe >

Who to Contact for Assistance

Contact the Quality Payment Program (QPP) Service Center by email at QPP@cms.hhs.gov, by creating a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday-Friday, 8 a.m. – 8 p.m. ET). People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

E-mails must be sent directly, not forwarded or Cc'ed, and must utilize the QPP e-mail address (QPP@cms.hhs.gov) in the **"To" line**. Inquiries forwarded to QPP@cms.hhs.gov or sent via e-mail with QPP@cms.hhs.gov in the "Cc" line may not trigger the creation of a case number for your inquiry.

To ensure that inquiries are routed to the appropriate subject matter experts, all inquiries must be submitted through the QPP Service Center and **NOT** the QCDR or Qualified Registry Support mailbox.

Processing all inquiries through the Service Center allows for consistent tracking and helps to ensure that inquiries are appropriately assigned and processed by the PIMMS team subject matter experts.

QCDR & Qualified Registry Support

Important program information, deliverable information and reminders, as well as CMS Trainings and Support Session invites and materials will be distributed from the QCDR Support mailbox (QCDRVendorSupport@GDIT.com) and/or the Qualified Registry Support mailbox (RegistryVendorSupport@GDIT.com). Please be sure to mark this e-mail(s) as a safe sender to ensure all e-mail communications are received without issues.

There have been instances where outside sources have attempted to fraudulently portray themselves as the QCDR Support or Registry Support. Any e-mail address claiming to be QCDR Support or Registry that isn't QCDRVendorSupport@gdit.com or RegistryVendorSupport@gdit.com isn't associated with CMS or MIPS QCDR/Registry Support Team (PIMMS Team). CMS and the MIPS QCDR/Registry Support Team (PIMMS Team) will never send e-mails requesting sensitive financial information.

Frequently Used Acronyms

Quality Payment PROGRAM

- ACO – Accountable Care Organization
- API – Application Programming Interface
- APM – Alternative Payment Model
- APP – APM Performance Pathway
- BAA – Business Associate Agreement
- CAHPS – Consumer Assessment of Healthcare Providers and Systems
- CAP – Corrective Action Plan
- CEHRT – Certified EHR Technology
- CMS – Centers for Medicare & Medicaid Services
- CQM – Clinical Quality Measure
- CY – Calendar Year
- DDS – Doctor of Dental Surgery
- DMD – Doctor of Medicine in Dentistry
- DO – Doctor of Osteopathy
- DPM – Doctor of Podiatric Medicine
- DVER – Data Validation Execution Report
- DVP – Data Validation Plan
- eCQM – Electronic Clinical Quality Measure
- EHR – Electronic Health Record
- EMA – Eligible Measure Applicability
- ET – Eastern Time
- HARP – HCQIS Access Roles and Profile
- HCQIS – Health Care Quality Information Systems
- HIE – Health Information Exchange
- HIPAA – Health Insurance Portability and Accountability Act
- IFC – Interim Final Rule
- IQR – In-patient Quality Reporting
- JSON – JavaScript Object Notation
- MACRA – Medicare Access and CHIP Reauthorization Act
- MD – Medical Doctor
- MFA – Multi-factor Authentication
- MIPS – Merit-based Incentive Payment System
- MVP – MIPS Value Pathway
- NPI – National Provider Identifier
- OD – Doctor of Optometry
- PBA – Performance-based Adjustment
- PCF – Primary Care First
- PDMP – Prescription Drug Monitoring Program
- PIMMS – Practice Improvement and Measures Management Support
- QCDR – Qualified Clinical Data Registry
- QP – Qualifying APM Participant
- QPP – Quality Payment Program
- QRDA – Quality Reporting Data Architecture
- SGR – Sustainable Growth Rate
- SIP – Seriously Ill Population
- TIN – Tax Identification Number
- VBP – Value-based Purchasing
- VOH – Virtual Office Hours
- XML – eXtensible Markup Language

Questions?

2023 Data Submission Reminder

Reminder: 4 Days Until the Close of the 2023 MIPS Data Submission Period

The Centers for Medicare & Medicaid Services (CMS) opened data submission for Merit-based Incentive Payment System (MIPS) eligible clinicians who participated in the 2023 performance year of the Quality Payment Program (QPP). Data can be submitted and updated until **8:00 p.m. ET on April 15, 2024.**