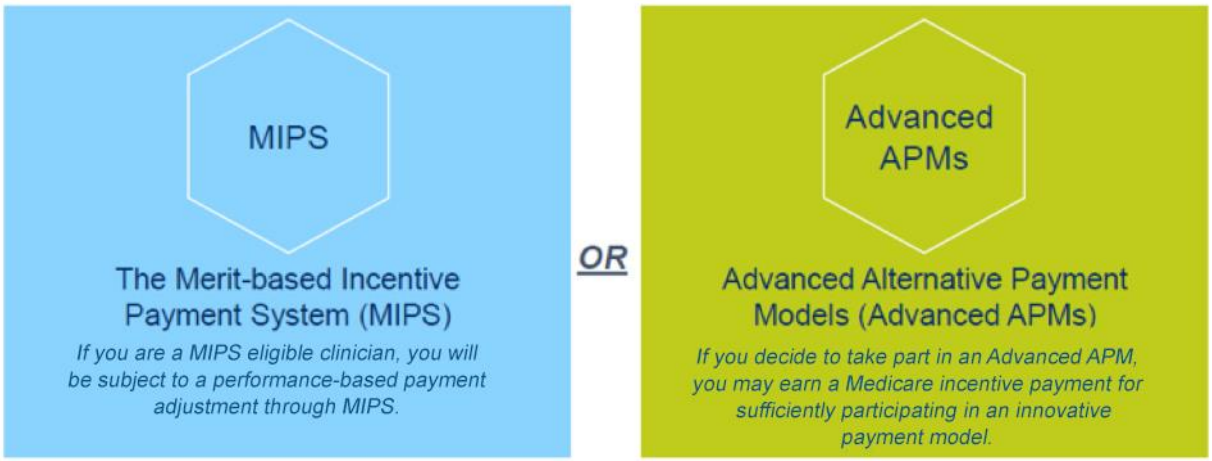
Quality Payment
PROGRAM

2019 MIPS Data Validation Criteria

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 requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:



This fact sheet provides a high-level overview of the criteria used to audit and validate measures and activities for the Quality Payment Program Year 3 (2019). Detailed criteria are included in the accompanying MIPS Data Validation Criteria spreadsheet.

MIPS Data Validation and Auditing

The Calendar Year (CY) 2019 Quality Payment Program final rule requires CMS to provide the criteria used to audit and validate measures and activities for the Quality Payment Program Year 3 for the Quality, Promoting Interoperability, and Improvement Activities performance categories.

Data validation is the process of ensuring that a program operates with accurate and useful data. MIPS requires all-payer data for all collection types except for the Medicare Part B claims and the CMS Web Interface collection types. The data from payers, other than Medicare, will be used for informational purposes to improve future validation efforts and will not be the only source of data used to make final determinations on whether you pass or fail an audit from the Quality Payment Program Year 3.

Under MIPS, CMS will conduct an annual data validation and audit process. If selected for a data validation or audit, you will have 45 calendar days to complete data sharing as requested or an alternate timeframe that is agreed upon by CMS and the MIPS eligible clinician or group.

What's the requirement if I use a third party to submit my MIPS data?

Third party intermediaries such as Qualified Clinical Data Registries (QCDRs), Health IT Vendors, Qualified Registries, or CMS-approved Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS Survey Vendors are required to comply with several procedures as a condition of their qualification and approval to participate in MIPS as a third-party intermediary, including providing the contact information for you and all individual clinicians or groups on behalf of whom submits data. In addition, entities must provide your phone number, address, and, if available, your email. Clinicians are encouraged to retain their own records, even when working with a third-party intermediary.

How long should I retain documentation?

In accordance with the False Claims Act, you should keep documentation up to six years and, as finalized in the CY 2019 Quality Payment Program final rule, CMS may request any records or data retained for MIPS purposes for up to six years.

For each of the performance categories, you will need to keep documentation for up to six years, excluding the Cost category.

- **Quality** - MIPS eligible clinicians, groups, and virtual groups should retain supporting documentation for the data submitted to the QCDR. If clinicians submitted six measures or less, less than the full measure set, or no outcomes/high priority measures were submitted, data documentation is required to validate whether you submitted all applicable MIPS measures and encounters using claims and registry data.
- **Promoting Interoperability** - keep documentation to support your submissions.
- **Improvement Activities** - the documentation used to validate your activities should demonstrate consistent and meaningful engagement within the period for which you attest.
- **Cost** - no data documentation is needed as clinicians do not submit cost measures; measures are calculated from Medicare claims by CMS.

Quality Performance Category

The MIPS Quality performance category assesses health processes and outcomes through quality measures.

MIPS eligible clinicians demonstrate quality performance assessed against a performance benchmark. The performance benchmark is based on historical or performance period data.

Quality Measures Data Submission via Medicare Part B Claims or Registry, if fewer than six

For the Quality Payment Program Year 3, CMS's data validation process for the Quality performance category will apply for Medicare Part B claims and registry submissions to validate whether you submitted all applicable MIPS measures and encounters when submitting fewer than six measures or when you do not submit the required outcome measure or other high priority measure, or submit less than the full set of measures in the applicable specialty set.

Qualified Registry and QCDR Quality Measures Data Submission

Qualified Registries and QCDRs must retain the data provided by the MIPS eligible clinician, group or virtual group to support the inputs and calculations of the individual Quality performance category measures. The Qualified Registry and QCDR need to retain the specific data elements and data used for each Quality performance category measure and the data used to calculate that reported measure. Examples of potential data elements for the specific Quality performance category measures are age range, drug prescriptions, lab tests, Healthcare Common Procedure Coding System (HCPCS) codes, and admissions. When the data comes from a certified electronic health record technology (CEHRT), the source of the data must also be retained. In addition, the Qualified Registry and QCDR should retain the data to support the calculation of the measure, such as denominator counts, denominator exception counts, and denominator exclusion counts. For ratio and risk-adjusted QCDR measures, specific supporting documentation requirements will be addressed in the future as more data and methods are available. The Qualified Registry, QCDR and MIPS eligible clinicians, groups or virtual groups must retain all data submitted to CMS for MIPS for six years for the 2019 performance period, and as specified for subsequent performance periods.

MIPS eligible clinicians, groups, and virtual groups should retain the supporting documentation for the data submitted to the Qualified Registry or QCDR.

Promoting Interoperability Performance Category

The MIPS Promoting Interoperability performance category (formerly the advancing care information performance category) replaced the Medicare EHR Incentive Program for eligible professionals, also known as Meaningful Use. The MIPS Promoting Interoperability performance category promotes patient engagement and the electronic exchange of information using CEHRT and continues CMS's commitment of promoting and prioritizing interoperability and improving patient access to health information. Under this performance category for Quality Payment Program Year 3, MIPS eligible clinicians report one set of objectives and measures based on the 2015 Edition CEHRT. Clinicians are required to report certain measures from each of the four objectives, unless an exclusion is claimed. Four objectives include:

- e-Prescribing,
- Health Information Exchange,
- Provider to Patient Exchange,
- and Public Health and Clinical Data Exchange

You should retain documentation to support all measure submissions for the Promoting Interoperability performance category.

Improvement Activities Performance Category

The MIPS Improvement Activities performance category assesses how much you participate in activities that make clinical practice better. Examples include:

- Activities related to ongoing care coordination

- Clinician and patient shared decision-making
- Regular use of patient safety practices
- Expanding practice access

Under this performance category in Quality Payment Program Year 3, you will be able to choose from a list of activities that represent a commitment to improving the functionality and quality of care a practice delivers. For the CY 2019 performance period, the period clinicians attest to engaging in improvement activities is a continuous 90-day period. The documentation used to validate your activities should demonstrate consistent and meaningful engagement within the period for which you attest.

Improvement Activities Helpful Hints:

- Activities are not Measures. It is important to distinguish Improvement Activities from MIPS quality measures that are found in the Quality performance category of MIPS. Unlike a quality measure, Improvement Activities represent activities that do not contain the elements of a quality measure. Improvement Activities do not have a numerator, a denominator, or exclusions. In addition, there is not a developed and tested calculation associated with an Improvement Activity.
- Certified PCMHs or Comparable Specialty Practices. CMS recognizes MIPS eligible clinicians or groups as being a certified patient-centered medical home or comparable specialty practice if they have achieved certification or accreditation as such from a regional or state program, private payer or other body that certifies at least 500 or more practices for certified patient-centered medical home accreditation or comparable specialty practice certification. In such a case, an individual or group can attest to the "IA_PCMH" activity instead of other activities in the Inventory and receive the maximum points for the Improvement Activities performance category.

  Working with QIN-QIOs. Some activities involve working with a CMS Quality Innovation Network-Quality Improvement Organization (QIN-QIO). A QIN/QIO Fact Sheet can be found here.
- Examples in the Inventory. The Improvement Activity listed in the Inventory may include examples of actions that can be taken to fulfill the requirements of the Improvement Activity. The eligible clinician would attest to the Improvement Activity listed in the Inventory when they submit their data for the Quality Payment Program Year 3.

Cost Performance Category

For the CY 2019 performance period, the Cost performance category is 15 percent of the final score. The Cost performance category uses your Medicare claims data to collect Medicare payment information for the care you give to beneficiaries during a specific period of time. Because we use Medicare claims data, we calculate the Cost performance category score and you do not have to submit any additional data. Therefore, Cost is not addressed in the accompanying MIPS Data Validation Criteria spreadsheet.

How do I get Help or More Information?

The Quality Payment Program can be reached at QPP@cms.hhs.gov or 1-866-288-8292 (TTY 1-877-715- 6222), Monday through Friday, 8:00 AM-8:00 PM Eastern Time.