

2018 Merit-based Incentive Payment System (MIPS) Performance Feedback and 2020 Payment Adjustment

Overview

Individual clinicians, groups, and clinicians participating in Alternative Payment Model (APM) Entities that are not determined to be “Advanced APMs” will receive MIPS performance feedback.

Qualifying APM Participants (QPs), and Partial QPs who did not elect to participate in MIPS, will NOT receive MIPS performance feedback.

Performance feedback includes measure-level performance data and scores, activity-level scores, category-level scores, your final score, and payment adjustment information.

- **Clinicians who practice in multiple groups (TINs)** will receive MIPS performance feedback for each group they participated in or were eligible to participate in. We've added [a new clinician role](#) that lets clinicians check performance feedback for all of their associated practices without requesting permission from each practice.
- **Clinicians who participate in multiple MIPS APMs** will receive MIPS performance feedback for each APM Entity they participate in as long as they are included on the MIPS APM participation list for each MIPS APM on 1 of the 3 snapshot dates. Their MIPS payment adjustment will be based on the APM Entity with the highest payment adjustment. These clinicians may contact the Quality Payment Program Service Center to find out how the MIPS payment adjustment will apply to them.
- **Clinicians and groups who voluntarily reported** will receive performance feedback, minus payment adjustment information, as long as they submitted Medicare part B claims between 9/1/2017 and 8/31/2018.

[Click here](#) for a list of the APMs whose Entities and participants will be able to access their 2018 MIPS performance feedback on qpp.cms.gov.

Frequently Asked Questions

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Have questions about a particular topic?

Click the links to jump ahead or use the “CTRL-F” function to enter key words.

Accessing Performance Feedback

How can I access my/our MIPS performance feedback?

You can access your performance feedback through the [Quality Payment Program website](#) by signing in with the same credentials that allowed you to submit and view data during the submission period.

If you don't have a QPP Account or QPP role for your organization, refer to the following resources for information on creating an account and requesting a role for your organization.

- [QPP Access User Guide](#)
- [How to Create a QPP Account video](#)
- [Connect to an Organization: Practice video](#)
- [Connect to an Organization: APM Entity video](#)
- [Connect to an Organization: Virtual Group video](#)
- Request the Clinician Role video (This will be available soon)

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Did you know?

We've added a clinician role that will let you view your performance feedback for all of your associated practices without requesting access to each practice.

If you're in a MIPS APM, this role also lets you directly access feedback and scores based on the APM scoring standard.

Please review the Connect to a Organization document in the [QPP Access User Guide](#).

Can third-party intermediaries access performance feedback?

Performance feedback preview can only be accessed by authorized group or practice representatives. CMS does not grant direct access to performance feedback for vendors or other third-party intermediaries because it will contain sensitive information, including payment and beneficiary information.

Vendors who have an account and a role for their Registry (or QCDR) organization can still access their dashboard and view the measures and activities they submitted on behalf of their clients, and the related scoring information. However, they will **not** see:

- data submitted directly by their client or by another third-party intermediary;
- quality or cost measures CMS calculated from administrative claims;
- beneficiary-level information for the administrative claims' measures;
- final score information; or
- payment adjustment information.

To view their clients' performance feedback, vendors would need a QPP Account and to submit a request for a role for each practice (TIN), virtual group, or APM Entity they represent. The Security Official for each organization would then need to approve the request, authorizing the vendor to access performance feedback. If their request is approved, they would be able to access that client's performance feedback.

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Navigating Performance Feedback: Individual Clinicians (Clinician Role)

I participate in a MIPS APM and am scored under the APM scoring standard. / My practice's security official denied my request for a Staff User role. How can I access my performance feedback?

You can request the 'Clinician role' from the Manage Access page of qpp.cms.gov. You'll need a QPP account to sign in. (Review the **Connect as a Clinician** document in the [QPP Access User Guide](#) for more information.)

Once you have this role, click the Performance Feedback tab to access available performance feedback for your associated practices and APM Entities.

I have the Clinician Role. Should I see all of my associated organizations in Performance Feedback?

Yes. You'll see one clinician record for:

- Each MIPS APM association;
- Each virtual group association; and
- Each group/practice association

You should see the same associations on the Performance Feedback tab as you see for 2018 in the QPP Status Participation lookup tool. Click **View Individual Feedback** to see performance feedback, including your final score and payment adjustment, as well as any individual data you may have submitted. (See below.)

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Navigating Performance Feedback: Individual Clinicians (Clinician Role)

The screenshot shows a web application interface for 'Performance Feedback' for the year 2018. On the left is a dark blue sidebar with navigation options: 'Eligibility & Reporting', 'Facility Based Preview', 'Performance Feedback' (highlighted with a red box), 'Manage Access', and 'Help and Support'. The main content area has a teal header with the title 'Performance Feedback' and subtitle 'Performance Year 2018'. Below this is a section titled 'Clinicians' with a search box labeled 'Enter full or partial NPI'. A red box highlights the text 'Showing 1 - 2 of 2 Clinicians'. Two clinician entries are listed:

- Jessica Larson with Ashville Medical**
NPI: 122234564 | TIN: 1234567890
This is an Alternative Payment Model Participant. Feedback will be based on the APM Entity (ACO) score. Feedback is applicable to all MIPS eligible clinicians within the ACO. You are part of a Shared Savings Program APM. [Learn More](#)
Participant in: Greenville ACO
Buttons: VIEW INDIVIDUAL FEEDBACK, Download Data
- Jessica Larson with Greenville Podiatry**
NPI: 122234564 | TIN: 333333333
Buttons: VIEW INDIVIDUAL FEEDBACK, Download Data

I have the Clinician Role and see both a Final Score and a Submission Score in my individual feedback. What's the difference?

These tabs appear for clinicians who submitted individual data in addition to (or as part of) the data used to determine their final score. (If there's only one submission associated with your TIN/NPI combination, you won't see these tabs and will only see performance feedback for the data used to determine your final score.)

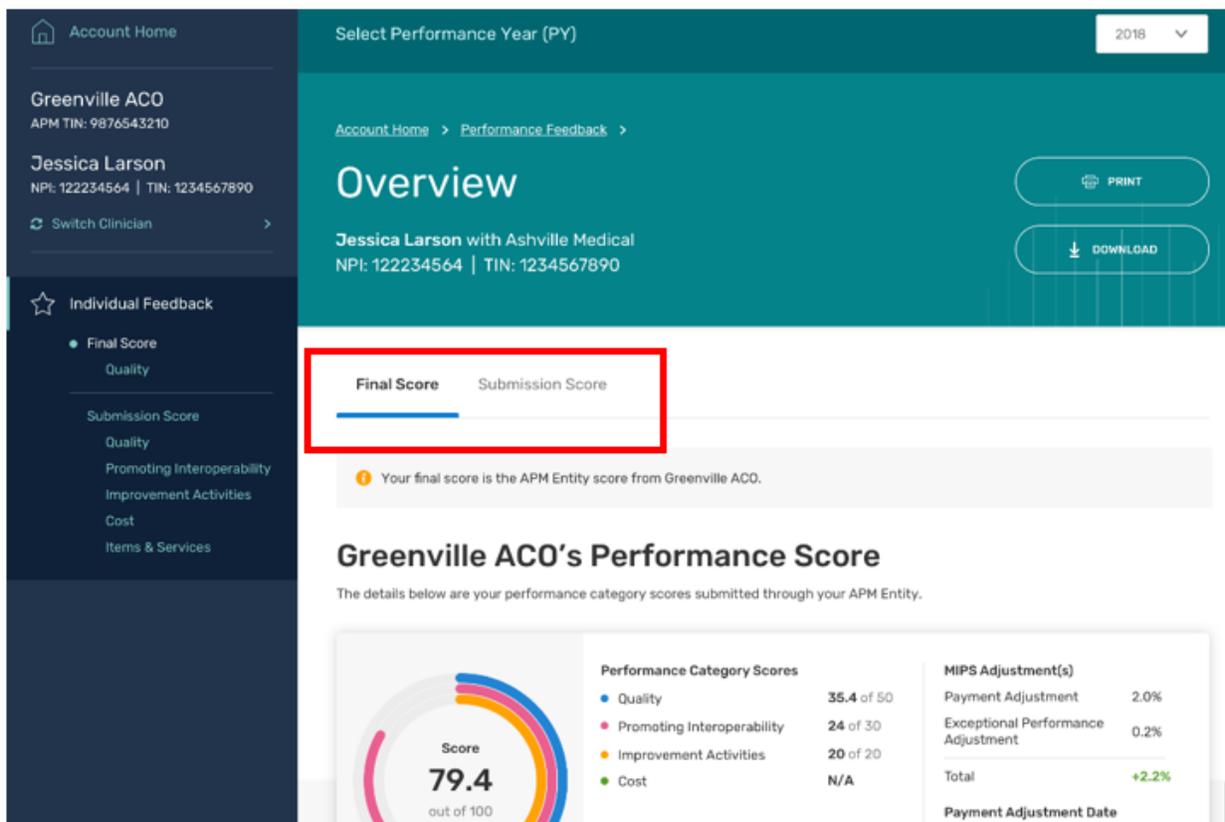
The Final Score tab provides feedback on the data that will be used to determine your payment adjustment under that TIN/NPI combination. The Submission Score tab provides feedback on individual data you submitted (or was submitted on your behalf) under that TIN/NPI combination.

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Navigating Performance Feedback: Individual Clinicians (Clinician Role)

Let's look at an example. "Jessica Larson" participates in a MIPS APM and is scored under the APM scoring standard.

- The **Final Score** tab displays her (the APM Entity's) score under the APM scoring standard because that's the score that will be attributed to her under this TIN/NPI combination.
- The **Submission Score** tab will display any individual (TIN/NPI level) data she submitted, including individual Promoting Interoperability data used to determine the APM Entity's score in this performance category displayed on the Final Score tab.



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Navigating Performance Feedback: Individual Clinicians (Clinician Role)

I'm a MIPS APM participant, and am scored under the APM scoring standard. What should I expect to see?

Once you have the Clinician role, you will be able to see the payment adjustment plus the APM Entity's final score, performance category scores (Quality, Improvement Activities, Promoting Interoperability as applicable), and your individual Promoting Interoperability score.

You will also be able to see scoring information for individual Quality measures if you participate in a Medicare Shared Savings Program ACO, Next Generation ACO or Comprehensive Primary Care Initiative Plus (CPC+) practice because these APM entities submit their quality measures to QPP. Model specific information is available [here](#).

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Navigating Performance Feedback: Practice Representatives

Our practice didn't participate/submit data as a group. What will we see in performance feedback?

If your practice did not submit data as a group for the 2018 performance period, you will see a message indicating that your clinicians only reported as individuals:

- “All clinicians in this practice reported as individuals. They will each receive a separate Final Score.”

There will be no scores or payment adjustment information in the group's feedback. Instead, you will access individual performance feedback for each Connected Clinician.

I see the term 'Connected Clinician' when I look our 2018 MIPS performance feedback. What's a 'Connected Clinician' and who is included in this list?

Connected clinicians are all clinicians (NPIs) associated with your practice (TIN) through Medicare Part B claims billed between 9/1/2017 and 12/31/2018 regardless of their individual MIPS eligibility. This list appears when you select '**Performance Feedback**' (from the home page or left-hand navigation), under the link to any group-level feedback.

We participate in a MIPS APM. / We have clinicians who participate in a MIPS APM. What kind of performance feedback will we see?

You will see performance feedback based on the data your practice submitted to QPP at the group or individual level.

Beginning with 2018 performance feedback, we will make final MIPS APM performance feedback available to the APM Entity and to the individual clinicians scored under the APM scoring standard (with the [appropriate permissions](#)). No APM scoring information will be available to practices (including ACO Participant TINs) with clinicians scored under the APM scoring standard.

We participate in a virtual group. Why don't I see our performance feedback?

Representatives of solo practitioners and practices participating in a virtual group must have a staff user role connected to the virtual group to access the virtual group's performance feedback. These permissions are different than the ones that let you access information specific to your practice. Please review the **Connect to an Organization** document in the [QPP Access User Guide](#).

Any data submitted by individual clinicians, solo practitioners or practices within the virtual group will be considered voluntary and not eligible for a payment adjustment.

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Navigating Performance Feedback: Virtual Group Representatives

We have clinicians who participate in a MIPS APM. What kind of performance feedback will we see?

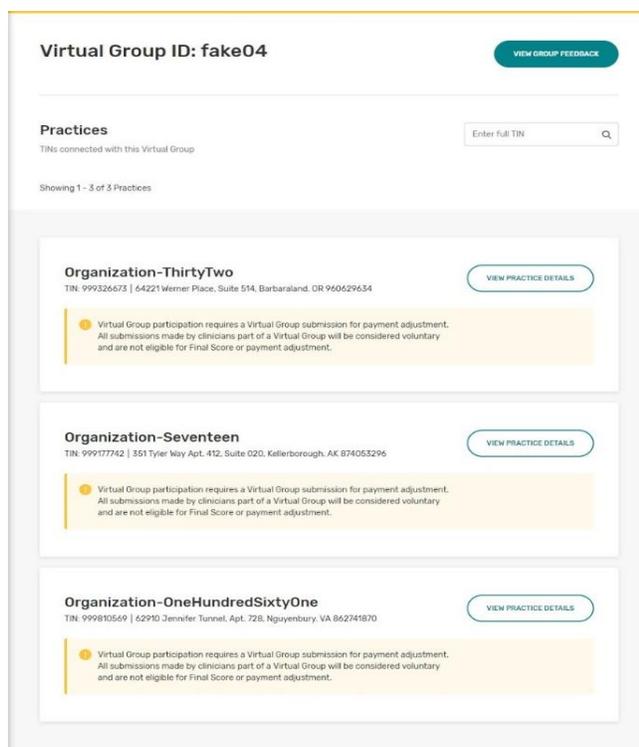
You will see performance feedback based on the data you submitted to QPP at the virtual group level. Beginning with 2018 performance feedback, we will make final MIPS APM performance feedback available to the APM Entity and to the individual clinicians scored under the APM scoring standard. No APM scoring information will be available to a virtual group with clinicians scored under the APM scoring standard.

Can the practices and/or solo practitioners who participate in our virtual group access our performance feedback?

Yes, if they have an approved Staff User role for your virtual group. This means they connected to your virtual group organization and requested the staff user role; these permissions are different than the ones that let them access information specific to their practice. For more information, review the **Connect to an Organization** document in the [QPP Access User Guide](#).

Can I access a list of the clinicians participating in our virtual group?

Yes. You can access a list of clinicians associated with each practice in the virtual group. Select View Practice Details next to each practice name.



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Navigating Performance Feedback: APM Entity Representatives

Can individual clinicians view our APM Entity feedback?

Yes. Beginning with 2018 performance feedback, we will make final MIPS APM performance feedback available to the APM Entity and to the individual clinicians scored under the APM scoring standard. The individual clinician will need to be approved for the [Clinician role](#) or be approved as a staff user by the APM Entity.

Representatives of participant TINs and practices with clinicians scored under the APM scoring standard will not be able to access the APM Entity's performance feedback unless they have been approved as a staff user by the APM Entity.

Can I access a list of the clinicians associated with our APM entity?

Yes. You can download this list by clicking the "View Participant Eligibility" link from the **Eligibility & Reporting** tab. Once you land on the Participating Practices screen, you can click on the link that says, "Download participant list" for a list of all Participating Practices and Clinicians at the APM. You can also click "Clinician Eligibility" for any of the practices to view the clinicians within that practice.

What should I expect to see in feedback?

Users with access to the APM Entity will be able to see payment adjustment information, plus the APM Entity's final score, performance category scores (Quality, Improvement Activities, Promoting Interoperability as applicable), and all of the individual or group Promoting Interoperability scores that contributed to the APM Entity's Promoting Interoperability scores.

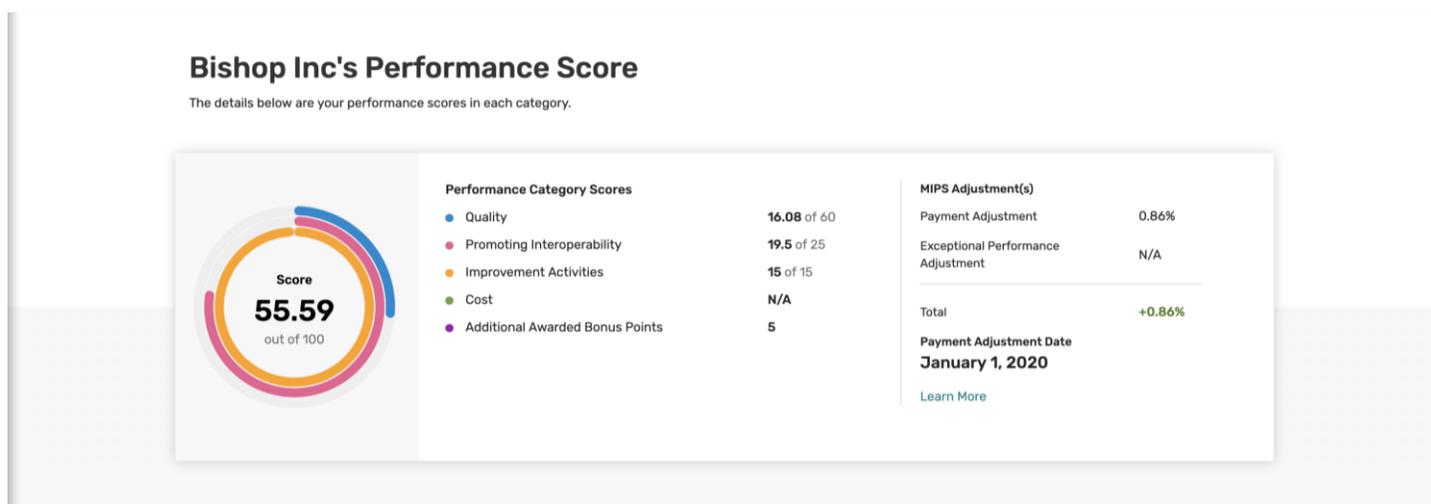
You will also be able to see scoring information for individual Quality measures if you represent a Medicare Shared Savings Program ACO, Next Generation ACO or Comprehensive Primary Care Initiative Plus (CPC+) practice because these APM entities submit their quality measures to QPP. More information is available [here](#).

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Overview: Final Score and Payment Adjustment

How is my final score determined?

Your final score is the sum of your performance category scores and any additional bonus points (your complex patient bonus, and, if applicable, your small practice bonus). Scroll down the **Overview** page to the **Additional Awarded Bonus Points** section for a breakdown of these bonus points.



Who gets the 2020 MIPS payment adjustment I see in performance feedback?

The payment adjustment information is specific to the final score that's being viewed. If you are viewing performance feedback for a **practice** (aggregated data for the entire group):

- This is the payment adjustment that will be applied to the MIPS eligible clinicians in your Connected Clinicians list **unless**:
 - They are individually eligible and have a higher payment adjustment from an individual submission under your practice,
 - They participate in a MIPS APM and are scored with their APM Entity, OR
 - They are Qualifying APM Participant (QP) or Partial QP that didn't elect to participate in MIPS.
- Your practice's Connected Clinicians list includes those clinicians who started billing Part B claims under your practice's TIN **between 9/1/2018 and 12/31/2018**. For more information on these clinicians please review the [2018 MIPS Eligibility Redetermination Fact Sheet](#) on the Resource Library.

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Overview: Final Score and Payment Adjustment

If you are viewing performance feedback for a **virtual group** (aggregated data for the entire group):

- This is the payment adjustment that will be applied to the MIPS eligible clinicians in your Connected Clinicians list.
- You can access the Connected Clinicians list for each practice in your virtual group.

If you are viewing performance feedback for an **APM Entity** with clinicians scored under the APM scoring standard:

- This is the payment adjustment that will be applied to the MIPS eligible clinicians in the APM Entity, **unless** they have a higher payment adjustment from a different MIPS APM.

For group, virtual group and MIPS APM participation, **MIPS eligible clinicians** includes clinicians who did not exceed the low-volume threshold as individuals but are not otherwise excluded from MIPS based on their:

- Clinician type/ specialty
- Medicare enrollment date
- Reaching QP thresholds if they are in an Advanced APM

If you are viewing performance feedback for an **individual** (not scored under the APM scoring standard):

- This is the payment adjustment that will be applied to that MIPS eligible clinician **unless** he or she has a higher payment adjustment based on a group submission from your practice.

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Overview: Final Score and Payment Adjustment

How does my payment adjustment relate to my final score?

Payment adjustments are determined on a sliding scale based on your final score.

Final score	Payment adjustment
70.00 - 100.00 points (Additional performance threshold = 70.00 points)	<ul style="list-style-type: none">● Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality)● Eligible for additional adjustment for exceptional performance (subject to a scaling factor to account for available funds)
15.01-69.99 points	<ul style="list-style-type: none">● Positive MIPS payment adjustment (subject to a scaling factor to preserve budget neutrality)● Not eligible for additional adjustment for exceptional performance
15.00 points (Performance threshold = 15.00 points)	<ul style="list-style-type: none">● Neutral MIPS payment adjustment (0%)
3.76-14.99	<ul style="list-style-type: none">● Negative MIPS payment adjustment greater than -5% and less than 0%
0-3.75 points	<ul style="list-style-type: none">● Negative MIPS payment adjustment of -5%

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Overview: Final Score and Payment Adjustment

Why is our payment adjustment so low when our final score is so high?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires MIPS to be a budget neutral program, which generally stated means that the projected negative adjustments must be balanced by the projected positive adjustments. The modest positive payment adjustment you see is a result of high participation rates in combination with a high percentage of participating clinicians earning a final score well above the relatively low performance threshold of 15 points. With so many clinicians successfully participating, the distribution of positive adjustments is spread across many more people. In fact, 98% of MIPS eligible clinicians submitted data, or otherwise avoided a negative payment adjustment, for the 2018 performance period.

The magnitude of the payment adjustment amount is influenced by two factors: the performance threshold and the distribution of final scores in comparison to the performance threshold in a given year. (The low-volume threshold, which is used to determine eligibility for the program, does not factor into the magnitude of the payment adjustment.) The program and incentives will continue to evolve. As the performance threshold increases and more accurately reflects the performance of clinicians in the program, the opportunity for larger payment adjustments also increases.

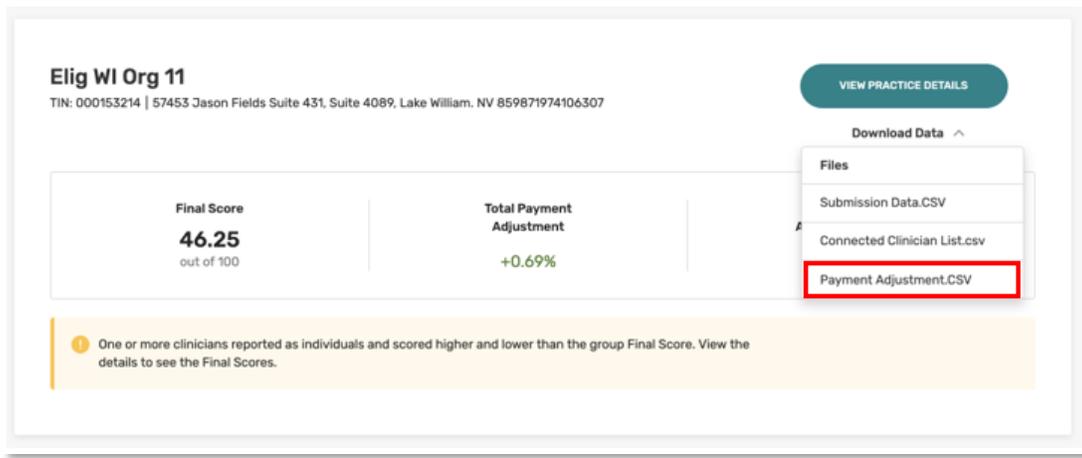
If you believe there is an error with your 2018 MIPS final score and 2020 MIPS payment adjustment(s), you should contact the Quality Payment Program or submit a targeted review request as soon as possible. Targeted reviews can be requested until September 30, 2019, but it is strongly recommended that targeted review requests are submitted sooner to ensure that payment adjustments are applied correctly as of January 1, 2020. If you need additional information, we have a [targeted review fact sheet](#) available on the QPP Resource Library.

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Overview: Final Score and Payment Adjustment

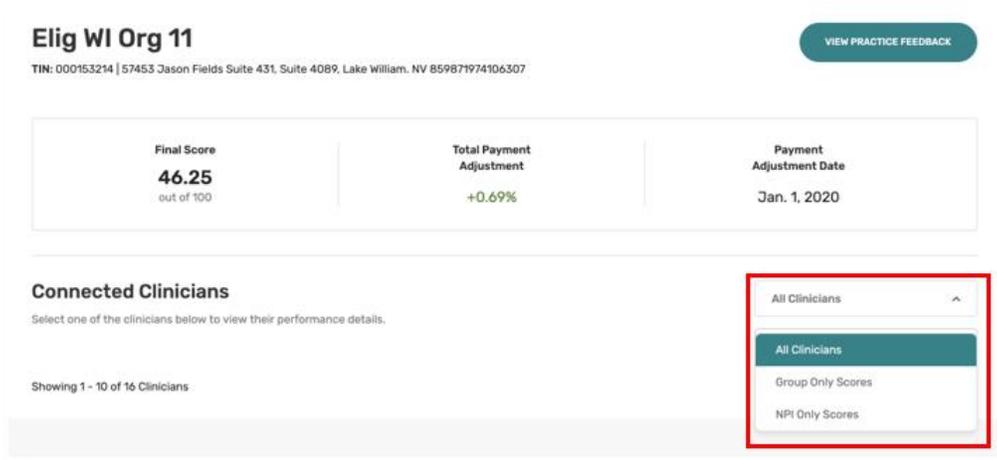
Is there a way for me to see a list of the final scores and payment adjustments for all the MIPS eligible clinicians in my practice?

Yes. From the **Performance Feedback** tab, select “Payment Adjustment CSV” from the **Download Data** menu under the **View Practice Details** button.



Note: There is currently no downloadable Payment Adjustment CSV for virtual groups or APM Entities.

You can also filter your Connected Clinicians list once you've clicked **View Practice Details**.



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Overview: Final Score and Payment Adjustment

NPI Only Scores

- Filters the Connected Clinicians list to show the clinicians who are **not** getting a final score and payment adjustment based on the group's submission

Group Scores

- Filters the Connected Clinicians list to show the clinicians who are getting a final score and payment adjustment based on the group's submission

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Quality

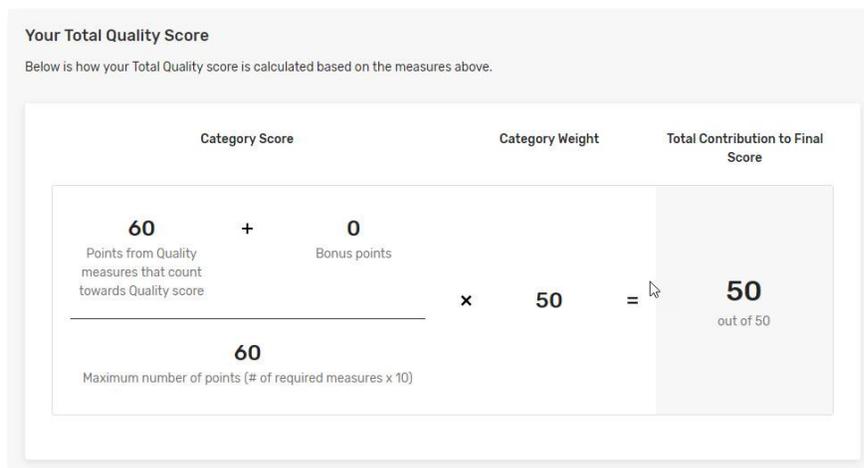
I submitted more than 6 measures. How did you determine which ones counted towards my Quality performance category score?

If you submitted more than 6 measures through a single submission method (e.g. by claims or EHR), we first selected your highest scored outcome measure, or other high priority measure if there were no outcome measures submitted. We then selected the next 5 highest scored measures. When there are multiple measures with the same score, we select measures for the top six based on (ascending) numerical order of the measure ID.

If you didn't submit an outcome or other high priority measure, you will only see 5 measures that counted towards the category score and a score of 0 out of 10 for the 6th required measure unless the [Eligible Measure Applicability process](#) determined that none were available to you.

Why don't I see Improvement Scoring in my Total Quality Score calculation?

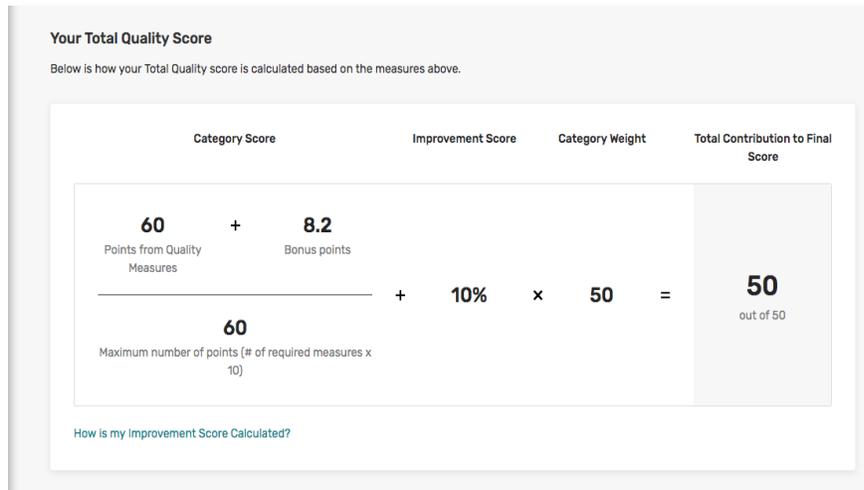
Just as with other aspects of feedback, we only display the data that's relevant to you. You will only see an Improvement Score if you qualified for it. For more information on how the Improvement Score is calculated, please review the [2018 MIPS Bonus Overview Fact Sheet](#).



These are the elements you will see if you did not qualify for an Improvement Score.

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Quality



What does it mean when I see a measure score of '--'?

If you reported through the CMS Web Interface, you will see '--' as the Measure Score for measures that were excluded from scoring because there is no benchmark, or because you did not meet case minimum.

Where can I access details about the measures I submitted?

Click the carat to the right of the measure score to expand and view the measure details such as measure type, numerator, denominator and data completeness.

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Quality

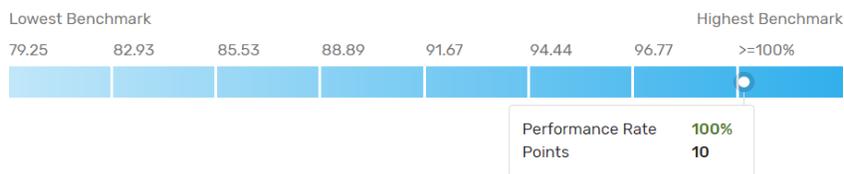
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

100%

10



Measure ID: 005



Measure Type

Process

[Download Specifications](#)

Details

Numerator	10000
Denominator	10000
Data Completeness	100%
Eligible Population	10000

Performance Points

Points from Benchmark Decile	10
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Bonus Points

High Priority Outcome or Patient Experience	0
Other High Priority	0
End-to-End Reporting	0

Measure Score **10**

Why are measures with higher performance rates not counted towards my Quality performance category score?

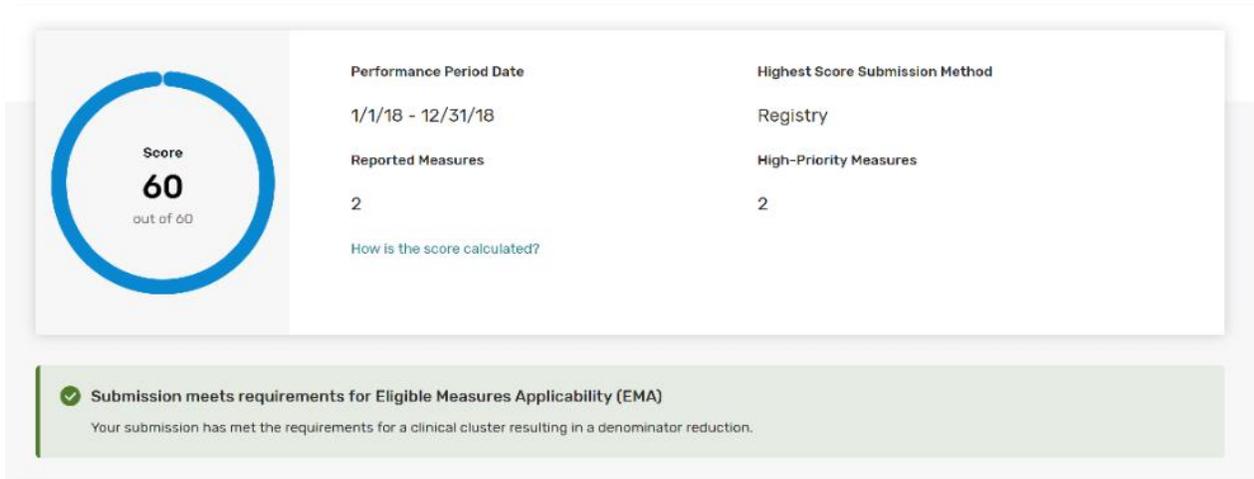
We included your highest scoring quality measures. Remember that scoring is determined by comparing the performance rate to the measure's benchmark. If you submit two measures, each with an 85% performance rate, one may earn 7 points while the other earns 10 points, based on the benchmarks for each measure.

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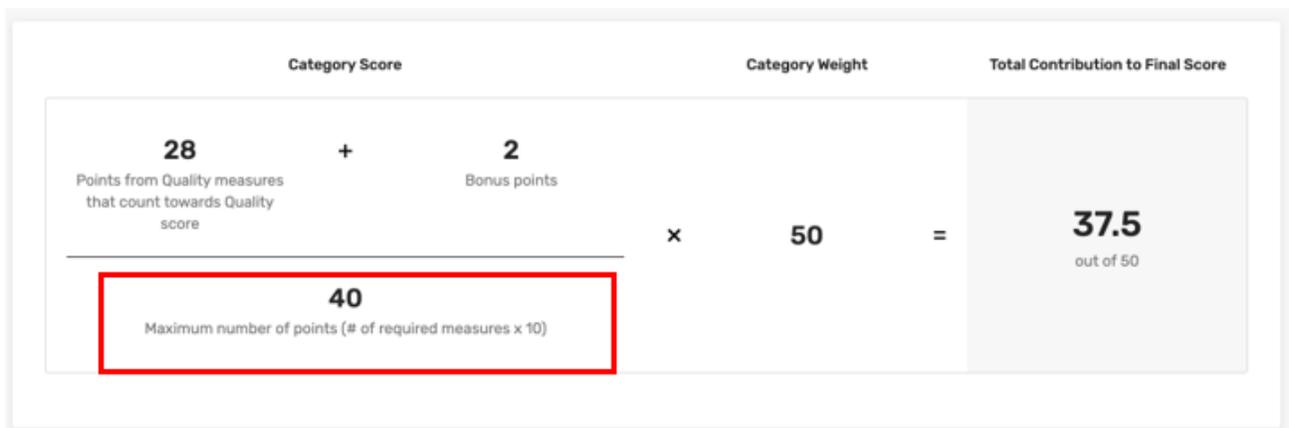
Quality

I submitted all of the Medicare Part B claims measures (or MIPS CQMs, “registry” measures) available to me. How do I know if the Eligible Measure Applicability (EMA) process was applied to my submission?

Your feedback will indicate whether your submission qualified for a denominator (“Total Possible Points”) reduction through the EMA process.



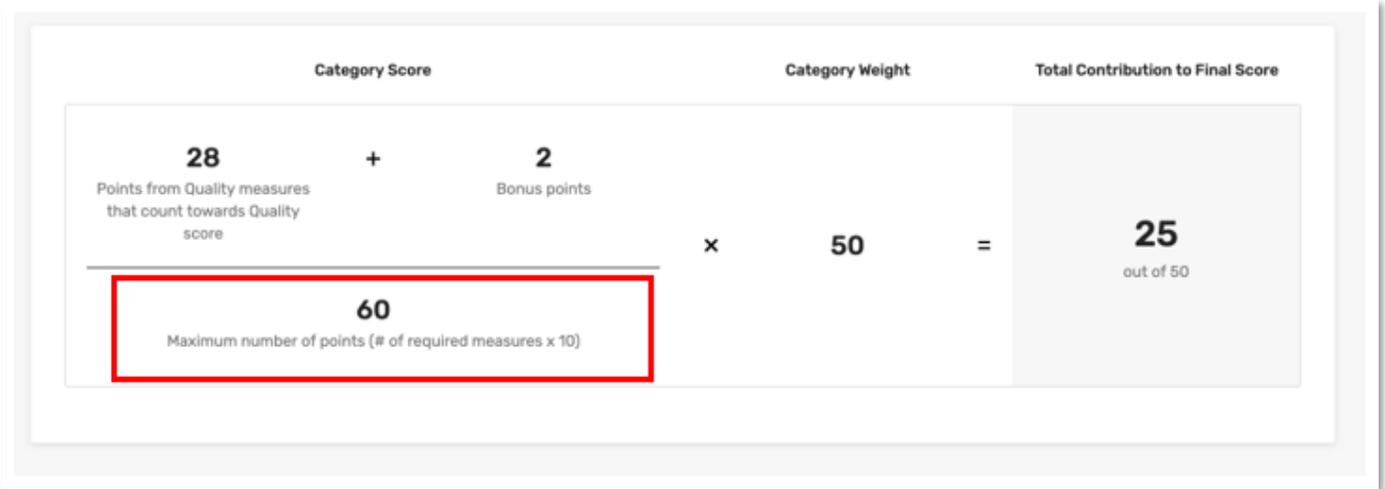
In the screenshot below, the Quality score calculations show a reduced denominator of 40 points, meaning there were 4 required measures.



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Quality

In the screenshot below, the Quality score calculations show a standard denominator of 60 points, meaning that you were accountable for submitting 6 measures.



If you submitted all available measures through claims or Registry and were still scored out of 60 Total Possible Points (or 70 if you participated as a group and were scored on the All-Cause Hospital Readmission measure), you may want to request a [targeted review](#) so we can take another look.

Where can I find information on the All-Cause Hospital Readmission (ACR) measure for our group?

We will only display the All-Cause Hospital Readmission (ACR) measure for groups who could be scored on the measure. This means that:

- The group included 16 or more clinicians; and
- The group met the case minimum (200 patients) for the measure.

If you don't see the ACR measure as part of your Quality score, then your group did not meet one or both of the criteria above.

The ACR measure is scored like other quality measures, where your group's performance earns points based on comparison to a benchmark. For more information about the measure itself, please review the [measure specifications](#), available on the QPP Resource Library.

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Improvement Activities

We are a certified patient-centered medical home. Why didn't we receive full credit in the Improvement Activities performance category?

If you're a MIPS eligible clinician practicing in a certified patient-centered medical home, including Medical Homes Model, or a comparable specialty practice, you'll earn full credit for the Improvement Activities performance category. Starting in 2018, 50% of practice sites within a multi-practice TIN (or TINs that are part of a virtual group) need to be certified or recognized as a patient-centered medical home to qualify for full credit in the performance category. In 2018 the term "recognized" is equal to the term "certified" as a patient centered medical home or comparable practice.

You are required to attest during the submission period to being a certified/ recognized patient-centered medical home to earn this credit.

Promoting Interoperability

Why did I receive a performance category score of 0 out of 25 points when I qualified for reweighting?

If a MIPS eligible clinician or group submitted any data for the performance category in which they were intending to be reweighted, CMS scored them according to the data submitted and the category was **NOT** reweighted to 0%.

Note: If you did not submit data and received a performance category score of 0 but should have qualified for reweighting based on your clinician type, special status, and/or hardship status, you may need to request a [targeted review](#).

We participate in a MIPS APM and submitted our Promoting Interoperability measures as individuals. Why is our score so much lower than what we saw during 2018 submissions?

The score you saw during submission was based on the individual or group data you submitted and is not your final Promoting Interoperability performance category score. Under the APM scoring standard, each MIPS eligible clinician in the APM Entity receives the same score which is a weighted average of all the scores for the MIPS eligible clinicians in the APM Entity.

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Cost

Why don't I see any cost measure information?

Only clinicians and groups who could be scored on at least one measure will see cost measure information in performance feedback.

If you don't see any cost measure details and see a score of 'N/A' in the "Final score at a glance", then you or your group did not meet the case minimum for either cost measure and the weight for this performance category was reallocated to another (typically Quality).

Can you explain the different elements displayed in the Medicare Spending per Beneficiary (MSPB) measure details?

Please refer to the descriptions below the screenshot.

The screenshot displays the Medicare Spending per Beneficiary (MSPB) measure details. At the top, the Measure Name is "Medicare Spending Per Beneficiary (MSPB)". To the right, two red boxes highlight "MSPB Average Cost Per Episode" and "Measure Score". Below this, the measure details are shown in a table format:

Measure Name	MSPB Average Cost Per Episode	Measure Score
Medicare Spending Per Beneficiary (MSPB)	\$21,858.00	5.8
Measure ID: MSPB_1		
Measure Info	Measure Details	
This data is based on claims information from all beneficiaries that were billed under Medicare in 2018. This is an inverse measure, where less spending indicates better performance.	Eligible Episodes	300
	MSPB Unadjusted Per Episode Cost	\$18,000.00
	MSPB Ratio	0.59
Reporting Period	Performance Points	
1/1/18 - 12/31/18	Partial Points Attributed	0.8
Download Bene Level Data	Points from Benchmark Decile	5
Note: We will not provide HIV/AIDS or mental health data in this file.	Measure Score	5.8

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Cost

MSPB Average Cost Per Episode:

- This figure represents your performance on the measure, from which we determine your “measure score.”
- It is the average of the ratio of payment-standardized observed to expected MSPB episode costs for all MSPB episodes attributed to the TIN-NPI or TIN, multiplied by the national average payment-standardized observed MSPB episode cost.

Measure Score (Points from Benchmark Decile + Partial Points Attributed):

- This is the number of points you earned (out of 10) on the measure.
- This score was derived by comparing your performance on the measure to the performance of all individual MIPS eligible clinicians, groups and virtual groups who were evaluated on the measure.

Eligible Episodes

- This represents the measure denominator.
- It is the number of eligible beneficiary episodes that were attributed to your individual TIN-NPI (if reporting as an individual clinician) or TIN (if reporting as a group) based on the MSPB measure attribution methodology. For detailed attribution methodology information, please refer to Step 5 on page 7 of the [2018 MSPB Measure Information Form](#).

MSPB Unadjusted Per Episode Cost:

- This figure is the un-adjusted, average, price-standardized observed cost of beneficiary episodes attributed to an individual clinician’s TIN-NPI or to all eligible clinicians under a TIN that participated in MIPS as a group.
- The figure is neither risk-adjusted nor normalized.

MSPB Ratio:

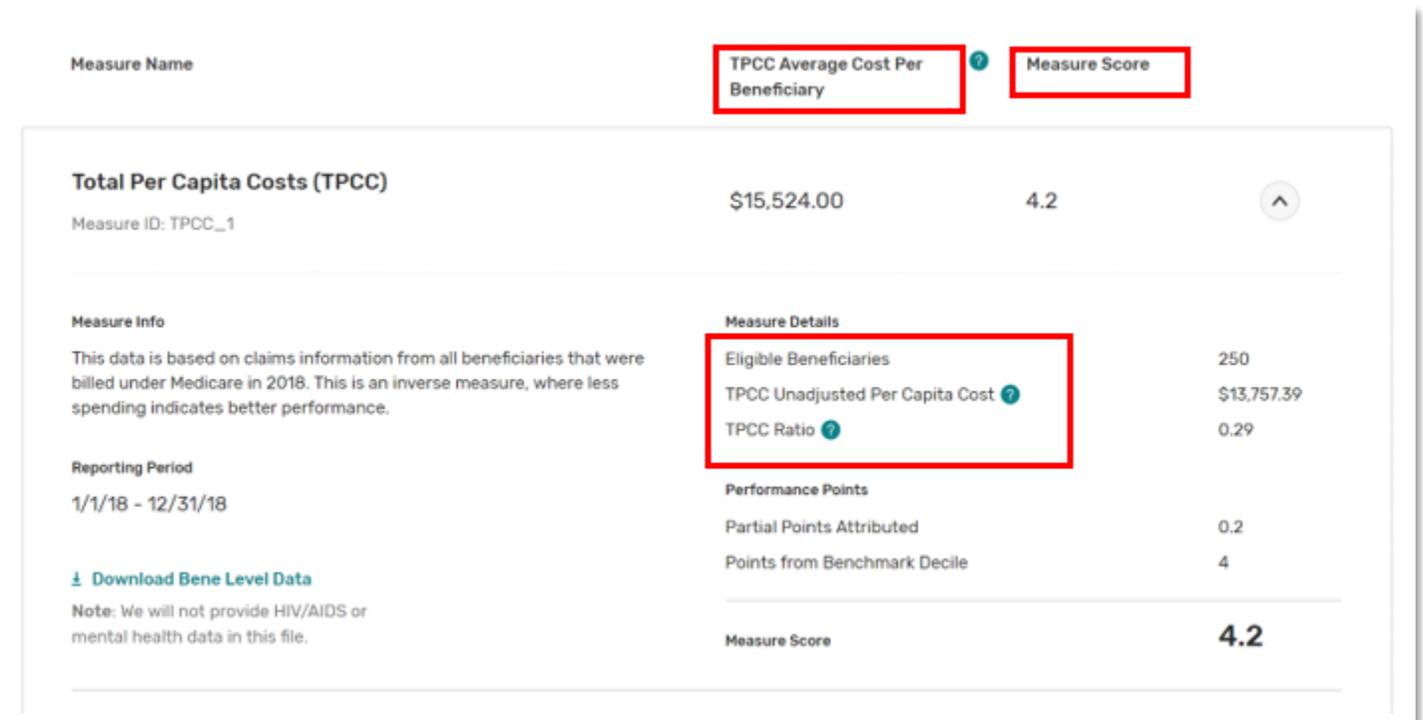
- The MSPB Ratio is the average of the ratios of payment-standardized, risk-adjusted, observed-to-expected MSPB episode costs calculated for each MSPB episode attributed to an individual clinician’s TIN-NPI or attributed to all eligible clinicians in a TIN that participated in MIPS as a group.

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Cost

Can you explain the different elements displayed in the Total Per Capita Costs (TPCC) measure details?

Please refer to the descriptions below the screenshot.



TPCC Average Cost Per Beneficiary:

- This figure represents your performance on the measure, from which we determine your “measure score.”
- It is the risk-adjusted, specialty-adjusted, normalized, payment-standardized, average amount of Medicare Parts A and B costs incurred during the 12-month performance period by all beneficiaries attributed to an individual MIPS eligible clinician’s TIN-NPI for individual reporting or to all individual eligible clinicians in a practice, identified by TIN, when participating in MIPS as a group.

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Cost

Measure Score (Points from Benchmark Decile + Partial Points Attributed):

- This is the number of points you earned (out of 10) on the measure.
- This score was derived by comparing your performance on the measure to the performance of all individual MIPS eligible clinicians, groups and virtual groups who were evaluated on the measure.

Eligible Beneficiaries

- This represents the measure denominator.
- It is the number of beneficiaries whose costs were attributed to your individual TIN-NPI (if reporting as an individual clinician) or TIN (if reporting as a group) based on the TPCC measure attribution methodology. For detailed attribution methodology information, please refer to Step 1 on page 5 of the [2018 TPCC Measure Information Form](#).

TPCC Unadjusted Per Capita Cost:

- This figure is the average, unadjusted, payment-standardized, annualized, observed (actual) per capita cost incurred during the 12-month performance period by beneficiaries attributed to the individual clinician or group.
- This value does not account for provider specialty nor beneficiary risk factors.

TPCC Ratio:

- The TPCC Ratio is the specialty-adjusted, risk-adjusted, per capita costs of beneficiaries attributed to an individual TIN-NPI or TIN divided by the simple, un-weighted mean of the specialty-adjusted, risk-adjusted, per capita costs calculated across all TINs or TIN-NPIs nationwide.
- This is your TIN or TIN-NPI's TPCC Average Cost Per Beneficiary divided by the national average TPCC Average Cost Per Beneficiary.

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Items and Services

What is the purpose of the Items and Services section of MIPS performance feedback?

The Items and Services section of your performance feedback includes information about your patients' health care utilization and emergency department use. The purpose of this breakdown is to provide clinicians and groups with additional information on the types of Medicare covered items and used by their patients throughout a calendar year. Please note that the Items and Services data is for informational purposes only and will not affect your MIPS performance scores.

How are you defining the types of Items and Services used by patients?

We define the types of items and services utilized by patients using Healthcare Common Procedure Coding System (HCPCS) codes. The HCPCS codes represent a standard coding system for procedures, supplies, products and services billed by health care providers. The data in the Items and Services section of performance feedback is aggregated by ranges of HCPCS codes for ease of review.

What is a HCPCS code and how are they classified by level?

The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into two levels:

- **Level I HCPCS Codes:** Codes and descriptors copyrighted by the American Medical Association's current procedural terminology, fourth edition (CPT-4). These are 5 position numeric codes representing services of physicians, non-physician practitioners and other suppliers.
- **Level II HCPCS Codes:** These codes are alpha-numeric codes consisting of a single alphabetical letter followed by four numeric digits. Level II HCPC codes are used primarily to identify products and services not included in the CPT codes, such as drugs and biologicals, or DMEPOS used in settings other than hospital inpatient, such as hospital outpatient departments, physicians' offices, and patients' homes. Level II codes and descriptors are maintained and distributed by CMS.¹

¹ <https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/2018-11-30-HCPCS-Level2-Coding-Procedure.pdf>

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Items and Services

What is a Current Procedural Terminology (CPT®) code?

Current Procedural Terminology (CPT®) codes offer doctors and health care professionals a uniform language for coding medical services and procedures to streamline reporting, and to increase accuracy and efficiency. All CPT codes are five digits and can be either numeric or alphanumeric, depending on the category. HCPCS Level 1 codes are on the American Medical Association's CPT codes.

How are HCPCS codes divided into sections in the Items and Services section of performance feedback?

In the Items and Services feedback, the HCPCS codes are categorized based on the following ranges of codes for ease of review:²

HCPCS Code	Definition of HCPCS Code Ranges
Level 1 HCPCS	
00000-09999	Anesthesia services
10000-19999	Integumentary system
20000-29999	Musculoskeletal system
30000-39999	Respiratory, cardiovascular, hemic, and lymphatic system
40000-49999	Digestive system
50000-59999	Urinary, male genital, female genital, maternity care, and delivery system
60000-69999	Endocrine, nervous, eye and ocular adnexa, auditory system
70000-79999	Radiology services
80000-89999	Pathology and laboratory services
90000-99999	Evaluation and management services
Level 2 HCPCS	
HCPCS A	Transportation services including ambulance, medical & surgical supplies
HCPCS B	Enteral and parenteral therapy
HCPCS C	Temporary codes for use with outpatient prospective payment system
HCPCS E	Durable medical equipment (DME)
HCPCS G	Procedures or professional services
HCPCS H	Alcohol and drug abuse treatment services or rehabilitative services
HCPCS J	Drugs administered other than oral method, chemotherapy drugs

² <https://hcpcs.codes/section/>

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HCPCS Code	Definition of HCPCS Code Ranges
HCPCS K	DME for Medicare administrative contractors (DME MACs)
HCPCS L	Orthotic and prosthetic procedures, devices
HCPCS M	Medical services
HCPCS P	Pathology and laboratory services
HCPCS Q	Miscellaneous services (temporary codes)
HCPCS R	Diagnostic radiology services
HCPCS S	Commercial payers (temporary codes)
HCPCS T	Established for state medical agencies
HCPCS V	Vision, hearing and speech-language pathology services

What data is being used in the Items and Services section of performance feedback?

The Items and Services section of performance feedback uses Medicare Part B professional claims (Claim Type 71 and 72) billed with dates of services between January 1, 2018 and December 31, 2018 with 60 days of runout.

Medical Services and Treatment

The categories below are associated with medical services or treatments provided. Each individual item or services has a correlated HCPCS or CPT I code.

Item/Service	Beneficiaries	Cost	Services
Anesthesia Services CPT I 00000-09999	200	\$12,000	301

How is the number of “beneficiaries,” in the Items and Service section of performance feedback, derived?

The number of beneficiaries reflected is the number of all beneficiaries for the related HCPCS/CPT codes on Part B professional claim lines with positive allowed charges.

For individual clinicians, this number includes all unique Part-B enrolled beneficiaries who received at least one service of any type from the individual clinician (identified by TIN-NPI) during CY2018 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2018.

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Items and Services

For groups, this number includes all Part-B enrolled beneficiaries who received at least one service of any type from any individual clinician (identified by TIN-NPI) who reassigned their billing rights to the group (identified by TIN) during CY2018 and received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2018.

How is the “cost,” in the Items and Service section of performance feedback, derived? Is the cost adjusted and/or price standardized in any way? If so, how?

The cost reflected in Items and Services is the sum of all positive allowed charge amounts for the related HCPCS/CPT codes on Part B professional claim lines. These numbers are raw allowed charge amounts and are not payment standardized, risk adjusted, nor specialty adjusted.

For individual clinicians, the number of services reflected is the sum of all Part B-enrolled beneficiaries' allowed charge amounts on professional claim lines for beneficiaries who received at least one service of any type from the individual clinician (identified by TIN-NPI) during calendar year (CY) 2018 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2018.

For groups, this number is the sum of all Part B-enrolled beneficiaries' allowed charge amounts on professional claim lines with allowed charges for beneficiaries who received at least one service of any type from any individual clinician (identified by TIN-NPI) who reassigned their billing rights to the group (identified by TIN) during CY2018 and received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2018.

How is the number of “services,” in the Items and Services section of performance feedback, derived?

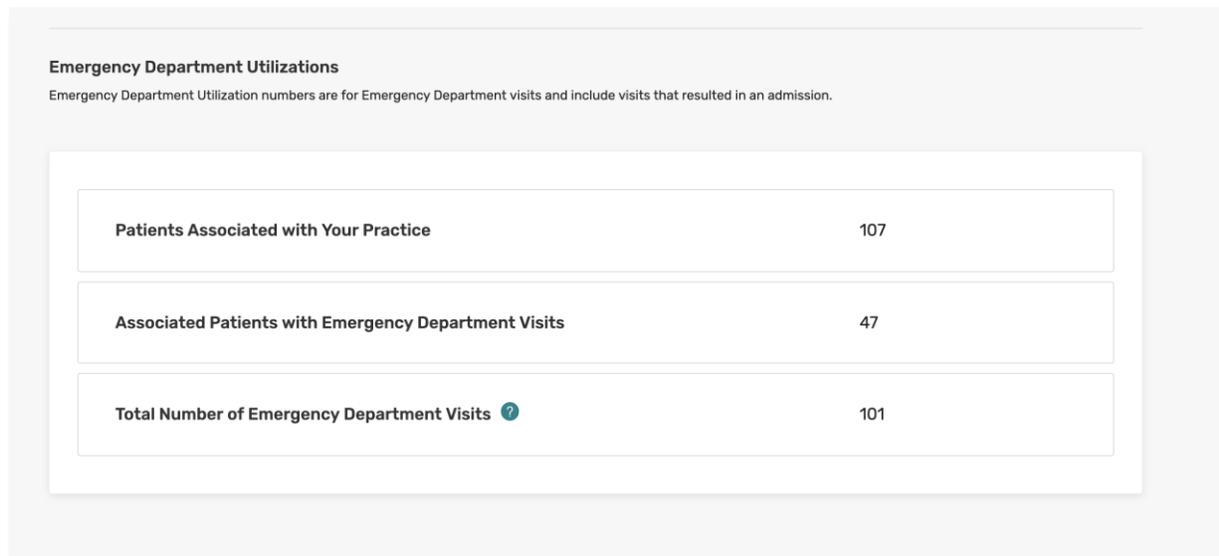
For individual clinicians, the number of services reflected is the sum of all Part B-enrolled beneficiaries' service unit quantity counts on professional claim lines with positive allowed charges for beneficiaries who received at least one service of any type from the individual clinician (identified by TIN-NPI) during calendar year (CY) 2018 AND received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2018.

For groups, this number is the sum of all Part B-enrolled beneficiaries' service unit quantity counts on professional claim lines with positive allowed charges for beneficiaries who received at least one service of any type from any individual clinician (identified by TIN-NPI) who reassigned their billing rights to the group (identified by TIN) during CY2018 and received at least one qualifying service (identified by relevant CPT code within the designated range) from any provider during CY2018.

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Items and Services

Emergency Department Utilization



The screenshot shows a table titled "Emergency Department Utilizations" with a subtitle: "Emergency Department Utilization numbers are for Emergency Department visits and include visits that resulted in an admission." The table contains three rows of data:

Emergency Department Utilizations	
Patients Associated with Your Practice	107
Associated Patients with Emergency Department Visits	47
Total Number of Emergency Department Visits 	101

Which beneficiaries are counted in the “patients associated with your practice” entry under the “Emergency Department Utilization” heading?

In this context, “patients associated with your practice” is defined as beneficiaries attributed to an individual clinician’s TIN-NPI or to a group’s TIN (depending on the chosen level of reporting) via the same two-step attribution methodology as used to compute the Total Per Capita Costs for All Attributed Beneficiaries measure (TPCC) measure, which is based on primary care services received in CY 2018.

For more information regarding the TPCC attribution logic, please refer to pages 9-10 of the [2018 Cost Performance Category Fact Sheet](#) and the [2018 TPCC Cost Measure Information Form](#).

Which beneficiaries are counted in the “associated patients with emergency department visits” entry under the “Emergency Department Utilization” heading?

This metric reflects the number of attributed beneficiaries who also had an emergency department (ED) visit in CY 2018. An ED visit is defined as any 2018 claim with a claim-line containing any of the following ED revenue center codes: 0450-0459 and/or 0981.

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Items and Services

How is the “total number of emergency department visits” entry under the “Emergency Department Utilization” heading defined?

The figure reflects the actual number of ED visits across all attributed beneficiaries in CY 2018.

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Performance Feedback for APM Entities and Clinicians Scored under the APM Scoring Standard

We participate in a MIPS APM. What kind of feedback will be available to us?

Beginning with the 2018 performance period, MIPS performance feedback for clinicians scored under the APM scoring standard will be available to the APM Entity and to the individual clinicians directly. The clinicians and entities participating in the following models will be able to access their performance feedback based on the APM scoring standard directly on qpp.cms.gov:

- [Medicare Shared Savings Program Accountable Care Organizations \(ACO\)](#)
- [Next Generation ACO Model](#)
- [Comprehensive ESRD Care \(CEC\) Model](#)
- [Comprehensive Primary Care Plus \(CPC+\)](#)
- [Oncology Care Model \(OCM\)](#)

Shared Savings Program ACO participants

	Overview	Quality (50%)	Promoting Interoperability (30%)	Improvement Activities (20%)	Cost, Items & Services
APM Entity	Can view: <ul style="list-style-type: none"> • Final Score • Payment Adjustment 	Can view: <ul style="list-style-type: none"> • Performance category score • Quality (measure data including the CAHPS for ACO survey) submitted to QPP on behalf of the Entity 	Can view: <ul style="list-style-type: none"> • Aggregated, weighted performance category score (“APM entity roll up”) • Scores attributed to each clinician in the Entity based on their ACO Participant TIN’s submission 	Can view: <ul style="list-style-type: none"> • A message that they’ve earned full credit for this performance category 	N/A

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	Overview	Quality (50%)	Promoting Interoperability (30%)	Improvement Activities (20%)	Cost, Items & Services
Practice (ACO Participant TIN)	<ul style="list-style-type: none"> • Can view a message that they have clinicians participating in an Alternate Payment Model • Cannot view any scoring information related to the APM scoring standard • Can view performance category scores and a final score based solely on the data submitted or calculated at the group level • Can view a payment adjustment based on the group's final score if there are clinicians in the group who will be scored based on the group's data 				
Individual Clinicians "Final Score" tab – click here for more information	Can view: <ul style="list-style-type: none"> • Final Score • Payment Adjustment 	Can view: <ul style="list-style-type: none"> • Performance category score • Quality measure data submitted to QPP on behalf of the Entity 	Can view: <ul style="list-style-type: none"> • Aggregated, weighted performance category score ("APM entity roll up") • Their individual score based on data submitted by their ACO Participant TIN 	Can view: <ul style="list-style-type: none"> • A message that they've earned full credit for this performance category 	<i>If you submitted individual data, you may see both Items & Services and Cost data as part of your submission data and/or "submission score" record</i>

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Next Generation ACO participants

	Overview	Quality (50%)	Promoting Interoperability (30%)	Improvement Activities (20%)	Cost, Items & Services
APM Entity	Can view: <ul style="list-style-type: none"> Final Score Payment Adjustment 	Can view: <ul style="list-style-type: none"> Performance category score Quality measure data (including the CAHPS for ACO survey) submitted to QPP on behalf of the Entity 	Can view: <ul style="list-style-type: none"> Aggregated, weighted performance category score (“APM entity roll up” – click here for more information) Scores attributed to each clinician in the Entity 	Can view: <ul style="list-style-type: none"> A message that they’ve earned full credit for this performance category 	N/A
Individual Clinicians “Final Score” tab – click here for more information	Can view: <ul style="list-style-type: none"> Final Score Payment Adjustment 	Can view: <ul style="list-style-type: none"> Performance category score Quality measure data (including the CAHPS for ACO survey) submitted to QPP on behalf of the Entity 	Can view: <ul style="list-style-type: none"> Aggregated, weighted performance category score (“APM entity roll up” – click here for more information) Their individual score based on data submitted at the individual or group level 	Can view: <ul style="list-style-type: none"> A message that they’ve earned full credit for this performance category 	<i>If you submitted individual data, you may see both Items & Services and Cost data as part of your submission data and/or “submission score” record</i>

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Comprehensive ESRD Care (CEC) and CPC+ participants

	Overview	Quality (0%)	Promoting Interoperability (50%)	Improvement Activities (50%)	Cost, Items & Services
APM Entity	Can view: <ul style="list-style-type: none"> Final Score Payment Adjustment 	N/A – quality data submitted for this model not available for performance feedback	Can view: <ul style="list-style-type: none"> Aggregated, weighted performance category score (“APM entity roll up” – click here for more information) Scores attributed to each clinician in the Entity 	Can view: <ul style="list-style-type: none"> A message that they’ve earned full credit for this performance category 	N/A
Individual Clinicians “Final Score” tab – click here for more information	Can view: <ul style="list-style-type: none"> Final Score Payment Adjustment 	N/A – quality data submitted for this model not available for performance feedback	Can view: <ul style="list-style-type: none"> Aggregated, weighted performance category score (“APM entity roll up” – click here for more information) Their individual score based on data submitted at the individual or group level 	Can view: <ul style="list-style-type: none"> A message that they’ve earned full credit for this performance category 	<i>If you submitted individual data, you may see both Items & Services and Cost data as part of your submission data and/or “submission score” record</i>

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Oncology Care Model (OCM)

	Overview	Quality (50%)	Promoting Interoperability (30%)	Improvement Activities (20%)	Cost, Items & Services
APM Entity	Can view: <ul style="list-style-type: none"> Final Score Payment Adjustment 	Can view: <ul style="list-style-type: none"> Performance category score but no details (data is submitted outside of QPP system) 	Can view: <ul style="list-style-type: none"> Aggregated, weighted performance category score (“APM entity roll up” – click here for more information) Scores attributed to each clinician in the Entity 	Can view: <ul style="list-style-type: none"> A message that they’ve earned full credit for this performance category 	N/A
Individual Clinicians “Final Score” tab – click here for more information	Can view: <ul style="list-style-type: none"> Final Score Payment Adjustment 	Can view: <ul style="list-style-type: none"> Performance category score but no details (data is submitted outside of QPP system) 	Can view: <ul style="list-style-type: none"> Aggregated, weighted performance category score (“APM entity roll up” – click here for more information) Their individual score based on data submitted at the individual or group level 	Can view: <ul style="list-style-type: none"> A message that they’ve earned full credit for this performance category 	<i>If you submitted individual data, you may see both Items & Services and Cost data as part of your submission data and/or “submission score” record</i>

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General

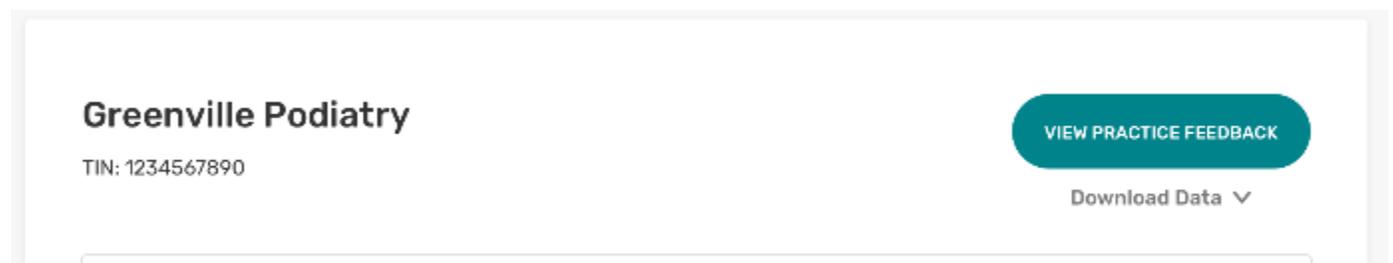
Why does my final performance feedback differ from my preliminary performance feedback?

When the 2018 submission period closed, CMS continued to make preliminary performance feedback available, providing information about scores in progress. Final MIPS Performance Feedback includes the following:

- Beneficiary-level data for the All-Cause Hospital Readmission measure, calculated using administrative claims data
- Beneficiary-level data for Cost measures, calculated using administrative claims data
- Performance on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey measure
- Improvement Activity credit based on successful participation in the CMS Study on Burdens Associated with Reporting Quality Measures
- Scoring updates based on the creation of performance period benchmarks for quality measures without a historical benchmark
- 2020 payment adjustment information for MIPS eligible clinicians
- Access to request a targeted review

I/We submitted data for the 2018 MIPS performance period through multiple mechanisms, why do I only see data submitted through one of them?

We will only display the highest scoring submission method for each category because this is the data that contributed to your final score. Data submitted through other submission methods, or that did not contribute to your final score, is available by selecting the Submission Data CSV from the Download Data option below the View Feedback link.



Greenville Podiatry
TIN: 1234567890

VIEW PRACTICE FEEDBACK

Download Data ▾

Can I download Feedback Reports?

Yes, you can print performance feedback using the **Print** button accessible on each page within Performance Feedback. (This feature uses your browser's native print functionality.)

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General

What if there's an error with my Payment Adjustment/Performance Feedback/Final Score?

If you believe an error has been made in your 2020 MIPS payment adjustment calculation, **you can request a targeted review until September 30, 2019 at 8:00pm (Eastern).**

However, we encourage you to contact the Quality Payment Program by phone, at 1-866-288-8293 (TTY 1-877-715-6222), or email, QPP@cms.hhs.gov, before submitting a targeted review if possible. You may be experiencing an issue we've already identified as impacting clinicians and groups and are working to address outside of the Targeted Review process. We can best serve you if you use the **Print** feature within feedback ("**save as PDF**") so we can attach this information to your case.

We continue to listen to you and make improvements to the system based on your feedback.

There may be slight variation between the information and screenshots in this document and what you see on your screen.

Contact the Quality Payment Program if you have questions about a discrepancy.

What's a targeted review?

A targeted review is a process where MIPS eligible clinicians, groups and MIPS APM participants (individual clinicians, participating groups and the APM Entity) can request that CMS review the calculation of their 2020 MIPS payment adjustment factor and, as applicable, their additional MIPS payment adjustment factor for exceptional performance. For more information on targeted review, please review the [Targeted Review Fact Sheet](#).

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