



Medicare Quality Payment Program: Deep Dive FAQs for 2017 Performance Year Data Mapping

This document supplements the [AMA's MIPS Action Plan – 10 Key Steps for 2017](#) and provides additional guidance on how to utilize new and existing data in association with the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA). After you understand the overall structure of the program, you (or your practice) will need to decide what data to collect, whether you will use a third party vendor for data collection or reporting, and answer other operational questions. This document addresses these considerations and provides higher-level strategic recommendations.

Relationship between MIPS and Prior CMS Programs

The Medicare Incentive Payment Program (MIPS) builds on earlier Medicare quality reporting and value-based payment programs, including the Physician Quality Reporting System (PQRS), Value-based Modified (VM), and Meaningful Use (MU) programs. If you have prior experience with these programs, this section provides guidance on how to leverage that past experience to help your performance in MIPS.

Q. I participated in previous CMS quality programs. Is there any data I can use from those programs to help me prepare for MIPS?

- A. If you've previously reported under Medicare's PQRS or VM programs, you can use CMS' Quality Resource Utilization Report (QRUR) to help you plan for MIPS reporting. The QRUR provides key information about PQRS and VM performance in prior years that can help you approximate how CMS might measure your performance on quality and cost measures in the MIPS program. While QRURs may show information about your performance in past programs like the PQRS or VM, they are not necessarily representative of how CMS will score your performance in the future since they do not include any information about the QPP or the Merit-Based Incentive Payment System (MIPS).

Specifically, the QRUR provides information on the following:

- Overall view of quality performance in past years
- List of professionals included in performance evaluation
- Performance data for individual clinicians

The QRUR reflects the performance of a Taxpayer Identification Number (TIN) on quality and cost metrics, as compared to all other TINs. As a result, the QRUR should provide a sense of your overall performance, and whether you have particular strengths and/or weaknesses to consider when preparing for QPP participation.

Q. Where can I find my QRUR?

- A. CMS makes QRURs available in the fall to reflect performance in the preceding year. You can access your QRUR on CMS’ website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>. To do so, you will need an [Enterprise Identity Management System \(EIDM\)](#) account. An account is also required for some aspects of QPP and other CMS programs, so if you don’t already have an account on file, you (or your representative) will need to create one.

Q. Are there specific parts of the QRUR that can help me design a better strategy for MIPS?

- A. Yes. The QRUR provides information about your overall performance and that of the other professionals included in the evaluation, and individual data that can be helpful.

Overall view of quality performance in 2015

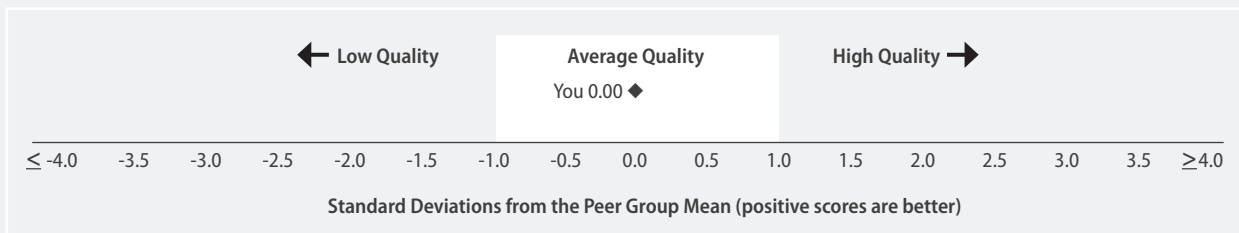
The QRUR provides a view of performance on the PQRS quality metrics, many of which are also included in MIPS. If performance on these metrics was positive, you may want to report the same quality measures under MIPS. If performance was poor, you should investigate why and identify a strategy for improvement or choose other quality measures to report under MIPS. Your efforts to improve your performance on a quality measure may qualify as an Improvement Activity (IA) in their own right, giving you IA points as well as a higher Quality score. The QRUR has some limitations because it is based on PQRS data, so it reflects a distinct set of quality measures (including some administrative claims measures automatically assigned by CMS). Your results under PQRS will not directly predict your performance under MIPS. However, the QRUR can give you a broad indication of your performance on a variety of representative quality measures relative to other physicians.

Example 1: Below is a sample excerpt from a QRUR showing performance in PQRS. In this example, the performance is 0.00 standard deviation from the mean for the peer group, or “Average.”

Performance on Quality Measures

Your TIN’s Quality Tier: Average

Exhibit 2: Your TIN’s Quality Composite Score



List of professionals included in performance evaluation

The QRUR provides a table, linked through CMS’ Enterprise Portal, that lists the physicians and non-physician eligible professionals identified in your Medicare-enrolled TIN (This information appears as “Table 1” on the [2015 sample QRUR](#) provided by CMS). Knowing who is included in your TIN is important because it will help you understand which clinicians’ performance will be included with your own for purposes of MIPS group reporting (recognizing that clinician rosters may change from year to year). The list of professionals will be most useful to validate your own understanding of the clinicians who bill through your group.

You can also use information about these professionals to decide whether or not to report to MIPS as a group or as an individual. If you report as a group, all individuals who bill through the group’s TIN will receive the same score. If you report as an individual, you will receive a score unique to your performance.

Additional information, including beneficiaries attributed to your TIN, and costs per beneficiary, are also included and may be of interest. Keep in mind, though, that CMS will not use cost as a metric for MIPS reporting in certain transition years.

Performance data for individual clinicians

The QRUR also provides data specific to individual clinicians, allowing you to see how each professional performed. This will give you an understanding of which clinicians were high or poor performers, and may allow you to tweak your reporting, data collection, or quality improvement strategy. It also may illustrate patterns of care that impact your choice of metrics. For example, if clinicians in your practice had trouble meeting the case minimums or achieving a high performance rate, you may wish to change the measures reported next year or change clinical processes to achieve better results.

Example 2: Below is a sample individual performance assessment on 2015 PQRS measures. You can access this assessment through your QRUR.

NPI	Eligible Professional Name†	Did eligible professional meet criteria to avoid 2017 PQRS payment adjustment?	PQRS or QCDR Performance Measure		Quality Domain	Eligible Professional Performance			Benchmark‡ (National Mean)
			Measure Reference	Measure Name		Reporting Mechanism†	Number of Eligible Cases†	Performance Rate	
#	Name A	Yes	111 (CMS127v2)	Preventive Care and Screening: Pneumococcal Vaccination for Older Adults	Effective Clinical Care	Claims	#	#.###%	#.###%

The QRUR also provides information on your costs, which is not initially relevant for MIPS, but may help you prepare for later years of the program when resource use (i.e., cost) will impact your overall score.

Of note, ACOs also receive QRURs (relevant to eligible clinicians scored through a MIPS APM); you can see an [example of an ACO's QRUR here](#). Sample [QRUR tables are available here](#).

Q. Can I use my prior experience with MU to improve my MIPS performance?

A. Yes. While the MU program for electronic health records (EHRs) is being phased out, the Advancing Care Information (ACI) component of MIPS builds on and streamlines previous MU requirements. Your experience in implementing a successful EHR system and reporting data under MU should help in the transition to ACI. Like MU, ACI requires you to use an EHR system that is certified by HHS (also called “Certified EHR Technology” or “CEHRT”) and requires you to attest to certain information regarding your practice’s use of EHR technology. However, the ACI category provides more flexibility than MU to eligible clinicians while reducing the number of reporting requirements.

In 2016, clinicians reporting through MU were required to attest to their performance on 10 objectives over a full year. [The list of MU measures for clinicians used in 2016 is here](#). This was an “all or nothing” structure; if the clinician could not demonstrate “meaningful use” via these measures, they would receive a negative Medicare payment adjustment. ACI requires you to report on all of the category’s base measures and awards additional points if you report on performance measures. Therefore, it offers the ability to earn “partial credit” to avoid a penalty, or to earn a positive payment adjustment. [Specifications for ACI measures are in this file](#). Although there is significant overlap between the MU and ACI measures, clinicians should carefully review the ACI measures they wish to submit.

Q. If MU is being replaced by MIPS, does that mean I don’t need to worry about reporting on MU categories anymore?

A. Not necessarily. CMS still operates a Medicaid EHR Incentive Program and a Medicare EHR Incentive Program for facilities.

Q. Now that MIPS is in place, do I need to submit reports each year for MU and PQRS as well?

A. No. PQRS, VM, and MU data reporting obligations have been rolled into MIPS. Clinicians are no longer required to report data through these programs. However, payment adjustments based on performance in these programs through the end of 2016 will be made through the end of 2018.

Q. We spent a lot of time developing data collection and reporting systems for PQRS and MU. Can I use these systems to transition to MIPS?

- A. Possibly. You may be able to complete MIPS reporting using the same method you used for PQRS and/or MU. At the same time, keep in mind that CMS will only use data from one reporting method to assign a score for each MIPS component. In other words, if you report on quality measures using both an EHR and a QCDR, CMS will only use data from one of these sources to calculate your MIPS Quality score. Specifically, CMS will use the data source that results in the highest score.

However, CMS will accept data from different sources for different MIPS components. For example, if you use a Qualified Registry to report data on quality measures but an EHR to report on ACI Measures, CMS will calculate a Quality and ACI scores using the applicable reporting method.

So, if your EHR system supports quality reporting, but you also have a strong track record of reporting quality information through claims, you should pick one or the other data source for 2017.

Optimizing Quality Data Reporting

In 2017, the MIPS composite score is based on three components: Quality, ACI, and Improvement Activities (IA). The Quality track will be the source of the majority of points for most MIPS eligible clinicians. This section provides strategic advice on how to leverage data to help you pick Quality measures that best reflect your practice.

Q. I see Quality measures that may apply to me, but I need more detail on the data I'm required to collect. Where do I get this information?

- A. CMS provides detailed specifications for each MIPS Quality Measure [in this zip file](#). Each measure has its own PDF file. There are three kinds of measure specifications for CMS-created MIPS measures: "registry" (for reporting using a qualified registry, a Qualified Clinical Data Registry (QCDR), or EHR), "claims," or the CMS web interface for group reporting. In addition, different QCDRs allow you to report on different measures, some of which are unique measures only available on a given QCDR. [CMS provides a full list of QCDRs](#), the measures they allow you to report, and any unique QCDR-specific measures.

Q. Are there other metrics (beyond the MIPS quality measures) I can use to report my data?

- A. Practices reporting through a QCDR may report so-called "non-MIPS" measures. These are measures that are not included in the nearly 300 MIPS Quality measures, but that CMS will accept when submitted by a QCDR. Despite the name, these measures will in fact be scored under the MIPS. This may be advantageous, particularly if a non-MIPS measure enables you to submit performance information about your practice that demonstrates high quality care.

The AMA has partnered with ReachMD to provide resources on MACRA. One of the podcasts provides a short discussion of how to engage with QCDRs, available here: <https://reachmd.com/programs/inside-medicares-new-payment-system/what-we-need-to-know-about-qualified-clinical-data-registries-qcdrs/8501/>

Q. What data do I need to consider when picking Quality measures that are best for my practice?

- A. Consider the following information when deciding which Quality measures to report. Each is discussed in more detail below:
1. The reporting method applicable to that measure (i.e., claims, registry, or web interface).
 2. The "denominator," or list of patients with certain demographic and clinical features, that you must report. In most cases, the denominator definition is based on a combination of patient demographics (e.g., age and gender), ICD codes reflecting a set of diagnoses, and HCPCS codes reflecting relevant procedures. Patients or encounters that fit these criteria are considered "denominator-eligible."
 3. The "numerator," or inclusion criteria for patients who receive certain clinical services or interventions (or, who have clinical features linked to the quality of care they receive). The numerator generally requires the

practice to identify patients who received certain interventions during a qualifying encounter (in some cases, the numerator is also identified by one or more HCPCS codes).

4. Any “exclusions” from the denominator, i.e., clinical or other features that cause a patient or encounter to be removed from the denominator as a matter of policy.
5. Any “not met” cases, i.e., denominator-eligible patients or encounters that count against the performance of the measure, because they did not receive the intervention identified by the numerator or for policy other reasons.

Example 3: The below is step-by-step example of reporting on a Quality measure.

Step 1

You must choose between a “claims,” “registry,” “EHR” or QCDR version of this measure depending on how you are reporting. This will be noted in the file name, but will also be noted on the document as follows:

2017 Options for Individual Measures: Registry Only

Step 2

The specification will then include a brief description of the measure, instructions for reporting the measure, and a description of the clinical settings in which it may be reported:

Description:

Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Instructions:

This measure is to be reported a minimum of once per performance period for patients seen during the performance period. There is no diagnosis associated with this measure. This measure may be reported by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Note: This Measure is appropriate for use in all healthcare settings (e.g., inpatient, nursing home, ambulatory except the emergency department. For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.

Step 3

The specification will then describe the denominator. This will include a general description of the patient population, a list of CPT codes defining the population, and any policy exclusions from the denominator. Encounters that meet the exclusion should not be included in the denominator.

Denominator:

All patients aged 65 years and older.

Denominator Note: Eligible clinicians indicating the Place of Service as the emergency department will not be included in this measure.

Denominator Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter

AND

Patient encounter during the performance period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

AND NOT

DENOMINATOR EXCLUSION:

Hospice services received by patient any time during the measurement period: G9692

Step 4

The specification will list conditions for the numerator of the measure. The specification will also provide guidance related to the interpretation of the numerator cases, and possibly billing and coding information related to these cases. In this case, the numerator criteria could be met in one of two ways. Note that any exclusions from the denominator would also be listed here; this measure does not have any denominator exclusions.

Numerator Options:

Performance Met: Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record (1123F)

OR

Performance Met: Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (1124F)

OR

Performance Not Met: Advance care planning not documented, reason not otherwise specified (1123F with 8P)

The numbers in parentheses are Quality Data Codes. CMS does not require physicians using a registry (including an EHR, QR, or QCDR) to report data using these codes, but a specific registry may require you to do so for operational purposes.

Q. How do I use the information on one of these specifications to report Quality data to CMS?

- A. The specifications provided by CMS contain detailed information on each of these elements. As an example, consider measure #47 (Care Plan – National Quality Strategy Domain: Communication and Care Coordination). For more information on how to find specifications, with a focus on claims reporting to avoid a penalty, check out the AMA’s One Patient, One Measure, No Penalty campaign at ama-assn.org/qpp-reporting.

Q. How can I use this information to determine whether I can get a MIPS score for this Quality measure, and to calculate my performance on the measure?

- A. In 2017, CMS will award a minimum score of 3 points for any measure that is successfully reported. If you meet CMS’ data completeness criteria you can achieve a higher score for a measure. CMS defines data completeness as reporting on a measure on at least 50% of your eligible cases and has a case minimum of at least 20 cases. If the measure can be scored, your “performance rate” is the number that will feed into CMS’s calculation of your overall MIPS Quality score.

You can calculate data completeness by adding all of the cases where one of the “performance met” or “performance not met” categories was satisfied and dividing this number by the denominator-eligible population as adjusted by any exclusions.

Your actual score for any quality measure will depend on your performance on and certain information (e.g., whether it is “topped out;” whether CMS has enough data to score the Measure, etc.) about the measure.

Data Completeness

$$= \frac{(\text{All "Performance Met" Encounters}) + (\text{All "Performance Not Met" Encounters})}{(\text{All Denominator Eligible Encounters}) - (\text{All Denominator Exclusions})}$$

So, if you have 100 denominator-eligible encounters in a performance period but you determine that only 90 of them meet one of the “performance met” or “performance not met” options, you would have a data completeness rate of 90%. Because this is greater than 50%, CMS could score this measure.

Your performance rate is determined by comparing the “Performance Met” encounters to the sum of “Performance Met” and “Performance Not Met” cases.

Performance Rate

$$= \frac{(\text{All "Performance Met" Encounters})}{(\text{All "Performance Met" Encounters}) + (\text{All "Performance Not Met" Encounters})}$$

In other words, if a clinician met the “Performance Met” standards for 20 of the 90 cases in the previous example, the clinician would receive a performance rate of 20/90 or 22% on this measure. CMS will then compare this performance rate to scoring criteria based on the measure’s benchmark to determine a score for the clinician on this measure. While we use the example of a clinician here, the same process would apply to reporting as a group.

Q. If I am already reporting through PQRS, can I simply continue to report the same data to CMS?

- A. No. While MIPS provides the choice of nearly 300 measures, clinicians had **more than 400** to choose from during the last year of PQRS. In addition, measure specifications may change from year to year. CMS may also change the reporting mechanisms that may be used to report a measure. For example, a measure that could have been reported on through claims and registry may only be reportable through a registry the following year. Clinicians should confirm they are using the most up-to-date version of measure specifications if they intend to report on measures that CMS carried over from PQRS.

Q. If I change my reporting method, will that change my substantive ability to report on certain Quality measures?

- A. Possibly. Different specifications apply to measures depending on whether they are reported through a “registry” (whether a clinical registry, QCDR, or EHR), claims, or the web-based interface. In addition, some measures are not available through certain reporting methods.

Q. If I change my reporting method, will that change my scoring?

- A. Yes. CMS will evaluate your performance on a measure by comparing it to a benchmark. A specific benchmark is established for each reporting method. For example, the same measure may be scored differently if reported through EHR rather than on claims.

Q. Are there specific benefits to using any given reporting method?

- A. Yes. CMS provides additional Quality measure points if you report electronic quality measures through Certified EHR Technology. CMS also provides bonus points for reporting measures that meet CMS’s definition of end-to-end reporting. To earn these points, you must use CEHRT to collect quality measure information and must submit the data to CMS (or transmit it to a third party) in compliance with certain electronic processing standards.

Q. Are there data collection strategies that can help me maximize my MIPS score?

- A. Clinicians should understand the specifications and the benchmark calculation rules for each measure they plan to report, including the implications of using a particular reporting method. As described elsewhere in this document, some measures are not available when using certain reporting methods. In addition, scoring standards for data reported through some reporting methods may require higher performance to achieve a similar number of points.

For the MIPS 2017 Partial and Full Year Tracks, any Quality measure must be reported over a period of at least 90 days. However, reporting over a longer period may ensure you meet the data completeness standard and case minimum. Therefore, there is an incentive to report data over a longer period of time, up to a one-year period.

You may want to use the information provided in QRURs to identify quality measures where you have performed well and consider reporting on those same measures, if available in the QPP. Sophisticated practices may want to report on additional quality measures because CMS will calculate your final quality score based off of your best performing measures.

Q. My practice realized we were incorrectly collecting or reporting the numerator or denominator of a Quality measure. Do we have the opportunity to fix this issue?

- A. It depends on the reporting method used and the reason for the error. If you are reporting on claims, you may not resubmit a claim simply to add or modify a Quality Data Code. If you are reporting using another method, you may be able to review the medical records of the applicable denominator-eligible patients and correct your measure data prior to submission to CMS. In all cases, the clinical intervention described by the numerator must be supported by the information in a patient’s medical record.

Q. What kinds of issues should I consider before selecting a vendor to submit data to CMS?

- A. Virtually every data reporting vendor will require you to enter into an agreement with them. Practices should understand the terms and conditions of working with a particular vendor. For example, practices should

understand any applicable licensing and/or registration fees. They should also understand whether the vendor will perform additional functions such as data analytics or internal data reporting (and, if so, whether these are included in the base contract costs).

Many practices choose to use QCDRs to collect and submit data to CMS. QCDRs can allow you to be much more flexible and targeted in the data you submit for MIPS. This is because they have the unique ability to submit data on non-CMS quality measures developed by third parties (including specialty societies). As such, a QCDR may help you submit the data that are most relevant to your practice.

As with all vendors, practices should understand the terms of working with each QCDR. In most cases, QCDRs are qualified by CMS to submit a specific group of quality measures (which may include measures submitted to CMS by other measure developers and QCDR-specific measures). While these measures are selected to provide good options to practices, they represent only a subset of the nearly 300 MIPS quality measures adopted by CMS. Practices should make sure they understand which specific quality measures are supported by their preferred QCDR.

Every QCDR must go through a rigorous CMS certification process. The list of CMS-certified QCDRs (including brief descriptions of the cost of participation, supported MIPS measures, and unique QCDR measures) [can be found here](#).

Q. What elements of each Quality measure should I track over the course of a year?

- A. Periodic internal tracking may be advantageous to understand your likely performance under MIPS. Further, it may provide you with the information you need if deciding whether to change the measures you report to take advantage of better performance on a different measure or to identify potential shortfalls in the case minimum. Finally, this practice may assist in the overall management of care quality. You may track your performance over the course of the year by conducting periodic reviews of numerator and denominator data. In addition, most vendors include built-in practice reporting functionality that allows you to get a sense of your performance over the year. However, the federal government does not legally require you to track information on a real-time basis.

Q. I don't see any measures that work well for my practice. Do I have any ability to propose new or additional measures?

- A. Yes, but only for future years. CMS has an annual process to accept proposed new Quality, ACI, and IA measures called the CMS "Call for Measures". While it may be difficult for individual clinicians to suggest new quality measures, CMS has entertained suggestions for new Improvement Activities from individual clinicians.

Special Data Reporting Considerations for Providers in APMs

Q. As a participant of an ACO, do I have different responsibilities to choose Quality measures than other MIPS eligible clinicians?

- A. Yes. Medicare Shared Savings Program (MSSP) ACOs in Track 1 are not considered Advanced APMs under the QPP rules so participants in these ACOs are subject to MIPS. Unlike other MIPS eligible clinicians, participants in an ACO do not pick quality measures for reporting. Instead, ACOs report on the MSSP-required quality measures and all clinicians on the ACO's Participation List receive the same quality score in MIPS based on the ACO's performance.

However, there are limited circumstances where an ACO participant still has to report data for MIPS purposes. Most commonly, this occurs when a physician practice joins an ACO too late to be included on a Participation List for a given year. While CMS allows individual clinicians to join or leave an ACO over the course of a year (as reflected by multiple "snapshot dates" each year), Shared Savings Program rules do not allow an ACO to add new entities during a year. Specifically, Shared Savings Program rules require an entity to provide CMS a final list of practice entity TINs by summer of the year before the performance year.

As a result, a physician practice that joined an ACO during the performance year would not be evaluated under the rules for ACO members and, therefore, would be required to report separately. Also, if an ACO fails to submit data on behalf of its members, each group or clinician may still report data separately under MIPS (provided the group or clinician can meet data submission deadlines and other rules).

Q. I'm in a MIPS APM that's not an ACO. Are there any unique data collection considerations for me?

- A. Possibly. CMS classified certain non-ACO value-based payment models (like the Comprehensive Primary Care+ model) as "MIPS APMs." As with ACOs, the program rules for these models require participants to collect and submit data on a set of quality measures established by CMS. These data will continue to be used to determine your eligibility for payment incentives under the program rules of each specific value-based payment model (for example, CPC+ must submit certain data on clinical quality measures to earn the CPC+ program's Performance-Based Incentive Payment). However, this data will not be used to calculate a payment adjustment under MIPS. Quality data will not contribute to the MIPS score of any participant in these models. Instead, for participants in these models, the MIPS score is based entirely on the ACI and IA categories.

Feedback and Public Reporting**Q. When will I receive feedback on my MIPS data, score, and payment adjustment?**

- A. CMS will provide you with an official feedback report each year, covering your performance in the prior year. CMS also plans to make certain information about your performance in the current year available to you through a "web-based dashboard."

MACRA requires CMS to make information about the size of any payment adjustment no later than 30 days prior to January 1 of the applicable year (i.e., December 1, 2018 for the 2019 payment adjustment). CMS has stated that it will make this information available earlier in the year "if technically feasible."

Q. What is the process for correcting errors, requesting a review, or challenging CMS's evaluation of my data?

- A. Once you receive information about your performance, you will have the opportunity to challenge this data. CMS suggests that you may raise issues including calculation errors, errors in applying MIPS exclusion rules, data quality issues on behalf of the clinician or a vendor, or mistakes on the part of CMS. The review must be requested within 60 days after the close of the data submission period, or no later than July 31 following the end of the reporting year. CMS may accept or decline the request for a targeted review or may request more information (which must be provided within 10 calendar days). While the administrative review process detailed here is available to all MIPS eligible clinicians, CMS will treat the conclusion of this review process as final. All decisions made by CMS at the conclusion of this process are final. According to CMS regulations, it will not provide any further review or appeal following this process.

Q. Is it true that data I submit through this program is publicly reported?

- A. Yes. CMS currently reports certain information reported by physicians and group practices on the Physician Compare site. It plans to expand this reporting to include information about MIPS clinicians and groups. Specifically CMS will report clinicians' names, performance under each MIPS category, the names of clinicians in AAPMs (and potentially the names and performance data for the AAPMs), and aggregate information for all eligible clinicians under MIPS.

Q. Will I have an opportunity to review and challenge any data before it is published?

- A. Yes. CMS will give physicians a 30-day period to review their data and contest potential inaccuracies. CMS notes that this may overlap with the targeted review period, and any data under review will not be publicly reported. CMS stated it would publish additional information about this process on the future. Clinicians looking for updates should check qpp.cms.gov.

Relationships with Vendors / Other Entities**Q. Are there any consequences if vendors fail to properly submit data?**

- A. Yes. Vendors must meet certain criteria to submit data to CMS. CMS has the power to place a vendor on probation for a performance period, or for the following performance period (meaning the vendor must submit a corrective action plan to remain authorized to submit data). CMS will automatically require a corrective action plan if a vendor has data inaccuracies including TIN/NPI mismatches, formatting issues, calculation errors, or

data audit discrepancies that affect more than 3 percent of the eligible clinicians or groups submitting data through the vendor. CMS will also update the public information it provides regarding the vendor, noting their poor quality. Errors reflecting more than five percent of eligible clinicians may result in the vendor being disqualified from submitting data the following year.

However, note that data submission failures or defects may only be identified retrospectively and may not afford full protection to any given clinician or group. Clinicians and groups must be diligent in evaluating the data submitted on their behalf to CMS and the feedback provided by CMS to preserve any ability to request corrections or targeted reviews. In addition, clinicians should ensure that their contracts with vendors include protection for them because if a vendor fails to submit successfully on your behalf you still could be subject to a penalty.

Q. If I don't yet have a reporting vendor, are there any specific features I should consider when evaluating vendors?

- A. Yes. Your vendor should understand and support the measures you intend to report. You should ensure that they have obtained all necessary certifications or qualifications necessary to submit data to CMS. You should also understand whether their reporting system works with your existing EHR and whether you will need to invest in additional infrastructure to facilitate this kind of reporting. You should also understand the exact scope of the vendor's responsibilities; for example, whether their products support reporting only on Quality measures or on all MIPS components.

Q. What questions should I be asking my EHR/QCQR/QR vendor during the year?

- A. Your vendor may be able to provide "snapshot" data to demonstrate your performance on the various MIPS components. This may allow you to improve performance or collect data on additional measures. You should also have a process established with your vendor to validate that data are being transmitted from your practice to the vendor correctly. CMS establishes certain requirements for some kinds of vendors related to reporting (for example, QCQR measure stewards must provide at least four feedback reports). However, individual vendors may offer additional reporting detail and frequency above and beyond the "floor" established by CMS.

Q. What kinds of assurances should I seek from a data reporting vendor?

- A. Your vendor contract should include representations as to the vendor's technical capacity to submit data, its good standing under all required CMS certifications for vendors, its ability to intake data from your existing systems, and its ability to accurately submit data to CMS. The vendor agreement should spell out the vendor's responsibilities to collect data on all patients and the terms and conditions related to any unique reporting functions (for example, if you are working with a QCQR that is reporting on a non-CMS measure, the agreement should detail rules applicable to data transformation and risk adjustment rules for such non-CMS measures). The contract should require the vendor to disclose whether or not it is required to operate under a corrective action plan and, if so, whether it has remained in compliance with such a plan. In addition, a vendor should not be excluded from the Medicare or Medicaid programs.

Q. What kinds of protection should I build into my contract with a data reporting vendor?

- A. The vendor should take responsibility for the bulk of your data submission to CMS. This means the initial submission of the data as well as the provision of additional data to CMS. You may wish to make the vendor responsible for requesting a targeted review as well; at a minimum, it should be required to provide you with the information necessary to request a targeted review and to respond to CMS questions. Finally, you should ask for indemnification against any costs you incur as a result of the vendor's actions—this should include any negative payment adjustments as well as any compliance claims associated with attestations provided on behalf of your practice.

Q. What other key elements should I make sure to include in a vendor contract?

- A. The contract should spell out the exact terms of the services provided by the vendor. Services may be limited to pure reporting to CMS, or may include provision of more sophisticated data analytics. In either case, the contract should include promises to submit and report all data accurately. In addition, the contract should

spell out the timeframe applicable to your data submissions as precisely as possible, including key dates for any internal data submissions or testing necessary to support the vendor's data submission to CMS. You should retain contractual rights to verify data that is to be reported and the ability to "double check" any calculations or data transformations performed by the vendor (for example, through certain audit rights).

Q. Should my vendor agreement include privacy protections?

- A. Yes. Because you will be providing access to protected health information (PHI), the contract should include a Business Associate Agreement (BAA) under which the vendor agrees to comply with the Health Insurance Portability & Accountability Act (HIPAA) and protect your patients' information. The contract should also include indemnification and insurance coverage obligations for the vendor in the event the vendor experiences a breach of PHI. Executing a BAA is required under HIPAA, and will assist you in demonstrating compliance with the Security Risk Analysis Base Measure for ACI. The AMA has additional resources on the HIPAA Security Rule and Risk Analysis at ama-assn.org/practice-management/hipaa-security-rule-risk-analysis.

Q. Can I use any of my existing relationships with other entities to help me study data and be strategic in what I report in MIPS?

- A. Yes. Many healthcare entities participate in wider networks that are dedicated to analyzing and reviewing health data and practice information. For example, physician practices may be part of Independent Practice Associations, Physician Hospital Organizations, or Clinically Integrated Networks that dedicate resources to evaluating quality data. In addition, hospitals and practices may have entered into service line agreements that allow access to claims data and other information related to physician services provided in a hospital. Practices should evaluate all potential sources of clinical data to gain access to the widest range of possible data and obtain additional guidance or establish partnerships to improve their ability to demonstrate high quality care through MIPS.