2021

# AAPC's MACRA MADE EASY

## Guidance for APM and MIPS Proficiency


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# AAPC's: MACRA Made Easy

## Guidance for APM and MIPS Proficiency

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was a monumental move toward healthcare reform. It set the wheels in motion for a new healthcare ideology, incentivizing clinicians to provide quality, cost-efficient care by sharing in the spoils collected from those who don't. The implications of MACRA are massive and not easily understood.

Like all problems that require complex strategies, MACRA presents known rules (and exceptions) while simultaneously raising unprecedented questions. Rather than analyze a decade of possible moves, this course is geared toward identifying decisions and actions clinicians need to make in 2021.

Students will come to understand the fundamentals of MACRA and the administrative burden its provisions place on clinicians. This knowledge is essential for healthcare business professionals who wish to help their practitioners secure positive payment adjustments and bonuses.

## Disclaimer

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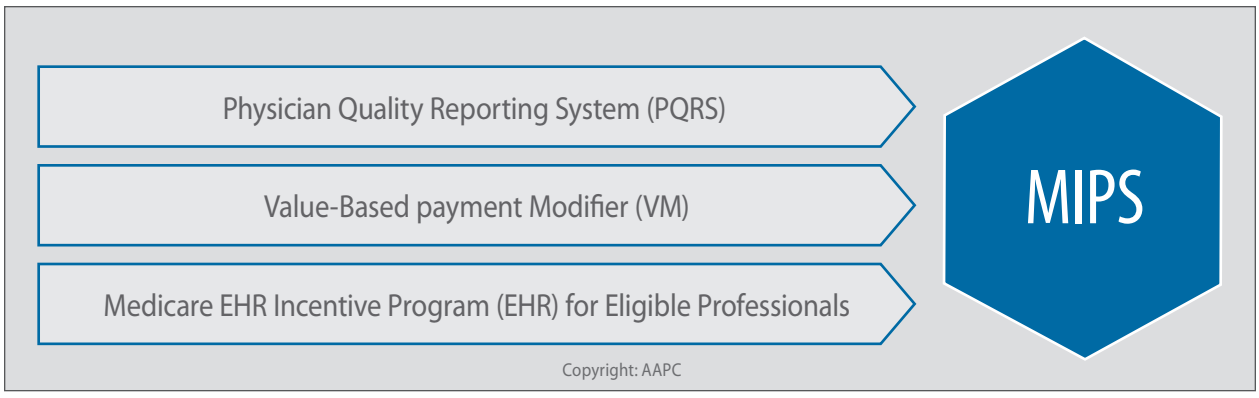
# Introduction

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)[1]: (1) repealed the sustainable growth rate (SGR) formula used to update the Medicare Physician Fee Schedule (MPFS); (2) reauthorized the Children's Health Insurance Program (CHIP); and (3) changed the way Medicare incorporates quality measurement into payments. Together, these policies are referred to as the Quality Payment Program (QPP).

The SGR was enacted under the Balanced Budget Act of 1997 to control Medicare spending[2]. The flaw in the system was that physicians' payment rates under the rule dropped so low that the SGR had to be suspended or adjusted by Congress every year to prevent physicians from opting out of Medicare. MACRA provided automatic, annual update to the single conversion factor of 0.5 percent for all physicians and other qualified healthcare professionals through 2019. Medicare Part B payment rates will stay frozen at 2019 levels through 2025. Beginning in 2019, eligible clinicians (defined later) will either receive negative, neutral, or positive adjustments to their Medicare Part B payments based on their performance in the Merit-Based Incentive Payment System (MIPS) or a MIPS Alternative Payment Model (APM), or earn a lump sum bonus for participation in an Advanced Alternative Payment Model (APM).

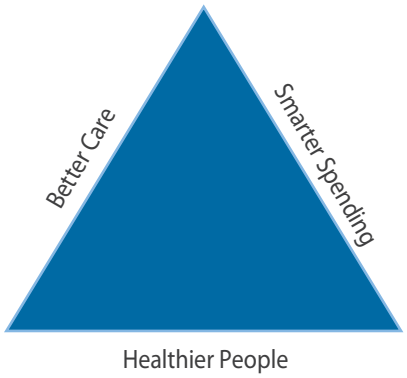
Under MACRA, Medicare's costly and complex quality initiatives — the Physician Quality Reporting System (PQRS), the Value-Based Modifier Program (VM), and the Medicare Electronic Health Record (EHR) Incentive Program, also known as Meaningful Use — ended on Dec. 31, 2018. Components of the PQRS, VM, and Meaningful Use programs live on in MIPS, however.




1 CFR 42 Part 414, Subpart O; www.law.cornell.edu/cfr/text/42/part-414/subpart-O

2 Sustainable Growth Rates & Conversion Factors; www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/index.html?redirect=/SustainableGRatesConFact/

The overarching goal of the QPP is to implement a patient-centered healthcare system that delivers **better care, smarter spending**, and **healthier people**. In theory, increasing the health of our population will reduce medical costs and preserve Medicare's main trust fund, which is on track to run dry by 2026[3].






3 Office of the Chief Actuary, 2018 Trustees Report, Actuarial Publications

Chapter 1

# Quality Payment Program Overview

The bedrock of the QPP is "high-value, patient-centered care, informed by useful feedback, in a continuous cycle of improvement."[4]

Quality care is tied to medical coding and medical coding is tied to reimbursement. The days of siloed expertise is a thing of the past and we must understand how each area of revenue cycle management (RCM) affects the next. Coders have a unique ability to understand how RCM works for both the physician and payer. To have a coder on the team who also understands the QPP is essential for clinicians who wish to receive full credit for the quality care they provide to patients.

The QPP is comprised of two payment methodologies:

- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)

Although there are two separate pathways within the QPP, both Advanced APMs and MIPS contribute toward the goal of seamless integration of the QPP into clinical practice workflows: Advanced APMs promote seamless integration by way of payment methodology and design that incentivize care coordination; and MIPS builds on the capacity of eligible clinicians to participate in APMs in later years of the QPP[5].

## Year 1 of the Quality Payment Program

The Centers for Medicare & Medicaid Services (CMS) published a final rule in 2016 to establish special policies for year 1 (performance year 2017/payment year 2019) of the QPP.

The Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models final rule (81 FR 77008, Nov. 4, 2016), or 2017 QPP final rule, established:

- Incentives for participation in Advanced APMs;
- The definition and processes for Qualifying APM Participants (QPs) in Advanced APMs;
- Criteria for use of the Physician-Focused Payment Model Technical Advisory Committee (PTAC); and
- Policies to phase in the implementation of MIPS.

## Year 2 of the Quality Payment Program

The 2018 QPP final rule further implemented policies established in the 2017 QPP final rule, and addressed elements of MACRA that were not included in the first year of the program, including:

- Virtual groups
- 2019 performance period facility-based measurement
- Improvement scoring

Added flexibilities were offered to small practices to alleviate perceived burden and several bonus opportunities were added to encourage participation.

### Automatic Extreme and Uncontrollable Circumstances

2017 was a memorable year. Hurricanes tore through entire communities in Florida and Puerto Rico and fires blazed through California, leaving entire communities without water, electricity, and shelter.

CMS released an interim final rule[6] concurrently with the 2018 QPP final rule to establish an automatic extreme and uncontrollable circumstance policy for year 1 of MIPS to recognize the 2017 hurricanes and other natural disasters that impeded many MIPS eligible clinicians' ability to participate in the QPP. In short, CMS applied the extreme and uncontrollable circumstances policies for all MIPS eligible clinicians in affected areas without requiring an application to be submitted. These MIPS eligible clinicians received a final score equal to the 2017 performance threshold (a term defined in Chapter 6).

## Year 3 of the Quality Payment Program

A third final rule, published in the Nov. 23, 2018, Federal Register, further implemented MACRA mandates and revised several previously finalized policies for year 3 (performance year 2019/payment year 2021) of the QPP.

Notable changes included:

- An expanded list of eligible clinician types
- An opt-in to MIPS option
- A third criterion to the low-volume threshold calculation
- Weight changes to the Quality and Cost performance categories

4, 5, 6 Quality Payment Program Year 2 Final Rule: www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-program-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme

According to CMS[7], 99.99 percent of eligible clinicians participated in MIPS in 2019 with 954,614 eligible clinicians receiving a payment adjustment. Of those who received a payment adjustment, 97.6 percent received a positive payment adjustment for payment year 2021 based on their performance in 2019.

Also, for the 2019 performance period, CMS reports that 195,564 eligible clinicians earned Qualifying APM Participant (QP) status, while another 27,995 eligible clinicians earned partial QP status.

Due to the public health emergency (PHE) for the COVID-19 pandemic, CMS reports that 65,237 (approximately 6.83 percent of 954,614) MIPS eligible clinicians received reweighting of one or more MIPS performance categories for year 3 under the MIPS Extreme and Uncontrollable Circumstances policy.

## Year 4 of the Quality Payment Program

The 2020 QPP final rule, published in the Nov. 15, 2019, Federal Register, continued to phase in previously finalized policies for year 4 (performance year 2020/payment year 2022) and introduced a radical change to how clinicians will select measures in the future.

Notable changes to the QPP for year 4 include:

- Weight changes to the Quality and Cost performance categories
- Payment threshold changes
- Payment adjustment changes
- Definition of hospital-based clinicians
- Proposed MIPS Value Pathways (MVP)

Due to the PHE for the COVID-19 pandemic, however, CMS finalized in the 2021 QPP final rule several changes to year 4 policy:

- An increase to the complex patient bonus. Clinicians, groups, virtual groups, and APM entities can earn up to 10 bonus points toward their final score for the 2020 performance year, only.
- APM entities may apply for reweighting of MIPS performance categories due to extreme and uncontrollable circumstances for the 2020 performance year, only. If approved, the APM entity will receive a score equal to the performance threshold.
- An extension for applying for reweighting due to extreme and uncontrollable circumstances for the 2019 performance period from Dec. 31, 2019, to Feb. 1, 2020.

In separate rulemaking[8], CMS also added a new COVID-19 Clinical Trials improvement activity to the CY 2020 Improvement Activities inventory for use beginning with the 2020 performance period (85 FR 19276-19277 and 85 FR 54848-54851).

This training will review the year 5 provisions of the QPP as finalized in the 2021 QPP final rule[9].

7 https://public-inspection.federalregister.gov/2020-26815.pdf

8 https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency

9 https://public-inspection.federalregister.gov/2020-26815.pdf

Chapter 2

# Eligibility and Exceptions

Not every healthcare provider is required to participate in the Quality Payment Program (QPP). First and foremost, payment adjustments only apply to professional services paid under Medicare Part B, so providers who don't accept Medicare Part B are excluded.

## MIPS Eligible Clinicians in 2021

For the 2018 performance year, the CMS defined eligible clinicians — identified by a unique billing Tax Identification Number (TIN) and National Provider Identifier (NPI) combination — as any of the following healthcare professionals[10]:

- Certified Registered Nurse Anesthetists (CRNA)
- Clinical Nurse Specialists (CNS)
- Doctors of Chiropractic (DC)
- Doctors of Dental Medicine (DMD)
- Doctors of Dental Surgery (DDS)
- Doctors of Medicine (MD)
- Doctors of Optometry (OD)
- Doctors of Osteopathy (DO)
- Doctors of Podiatric Medicine (DPM)
- Nurse Practitioners (NP)
- Physician Assistants (PA)

For performance year 2019, CMS expanded this list to include the following eligible clinicians for the purposes of MIPS participation:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Qualified Speech-Language Pathologists
- Qualified Audiologists
- Registered Dietitian or Nutrition Professionals

This list is unchanged for year 5 (performance year 2021/payment year 2023).

All MIPS eligible clinicians, including those in a MIPS APM, may participate in MIPS as an individual, group, virtual group, or (new for 2021) an APM entity.

10 Quality Payment Program Year 2 Final Rule: www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-program-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme

### 2021 Low Volume Threshold

The above-listed clinician types are automatically considered eligible clinicians if they meet or exceed the low-volume threshold. Beginning with performance year 2019, a MIPS eligible clinician:

- Earns greater than **$90,000 in Medicare Part B allowed charges;** and
- Earns greater than **200 Medicare Part B patients;** and
- Provides greater than **200 covered professional services** under the Medicare Physician Fee Schedule (MPFS).

CMS estimates approximately 228,000 clinicians will be MIPS eligible because they exceed the low volume threshold as individuals and are not otherwise excluded. CMS identifies these clinicians as having "required eligibility." Of those required to participate, CMS estimates 27,115 (10%) will choose not to participate.

As in performance year 2020, eligible clinicians who do not meet all three criteria are excluded from MIPS but may voluntarily report. Voluntary reporters do not receive payment adjustments and their performance results will not be published on the CMS Physician Compare website if they choose to opt out. The advantage of voluntary reporting is to generate feedback reports the clinician/group can use to prepare for future participation in the QPP; it also helps CMS improve the accuracy of benchmarks used to evaluate measures.

Beginning in 2019, eligible clinicians who meet at least one criterion (but not all three) may opt-in to MIPS. For example, an eligible clinician who receives $90,000 in allowed Medicare charges but sees fewer than 200 patients and provides fewer than 200 professional services may opt-in to MIPS. Those who opt in are considered MIPS eligible clinicians and will receive payment adjustments based on performance.

MIPS eligibility is based on two consecutive 12-month look-back periods that align with the fiscal year, beginning on Oct. 1. For 2021, the two determination periods are Oct. 1, 2019, to Sept. 30, 2020, and Oct. 1, 2020, to Sept. 30, 2021. Eligibility for the upcoming performance period is based on only the first 12-month period.

An eligible clinician may also be excluded from MIPS payment adjustments if one or more of the following is true:

- The clinician is a Medicare freshman.
- The clinician is a Qualifying APM Participant (QP) or Partial QP (PQP) in an Advanced APM (defined later).

### Significant Hardships

There are automatic exclusions (based on the low volume threshold) from MIPS and then there are exceptions, which may or may not require application. For example, MIPS eligible clinicians without access to certified electronic health record technology (CEHRT) due to a significant hardship, such as decertification of their electronic health record (EHR), can apply to have the Promoting Interoperability (formerly Advancing Care Information) category reweighted to zero (the weight is then transferred to the Quality performance category).

For performance year 2018, CMS added a significant hardship exception from the Promoting Interoperability performance category for MIPS eligible clinicians in small practices (defined in Chapter 4). To apply for a significant hardship for performance year 2021, clinicians had to submit a significant hardship application to CMS by Dec. 31, 2020.

CMS makes other exceptions for small practices, practices located in rural areas; non-patient-facing individual MIPS eligible clinicians or groups; and individual MIPS eligible clinicians and groups that participate in a MIPS APM or a patient-centered medical home.

To date, CMS has not imposed a time limitation for the number of years a clinician can apply for a significant hardship exception.

### Extreme and Uncontrollable Circumstances

For the 2021 performance period, there are no changes to this policy for individual clinicians, groups, and virtual groups. However, beginning with the 2020 performance period, APM entities may also apply for reweighting of all MIPS performance categories. APM entity groups will receive a score equal to the performance threshold even if data are submitted. As in previous years, however, individual clinicians, groups, and virtual groups that submit data override the approved reweighting on a category-by-category basis.

For performance years 2021 and 2022, the minimum Quality performance score for an ACO affected by an extreme and uncontrollable circumstance during the performance year will be set equal to the 30th percentile MIPS Quality performance category score. CMS states in the 2021 QPP final rule, "If an ACO is unable to report quality data and meet the MIPS Quality data completeness and case minimum requirement due to an extreme and uncontrollable circumstance, we will apply the 30th percentile MIPS Quality performance category score."

**Note:** CMS states in the 2021 MPFS final rule that it anticipates the PHE for COVID-19 to continue into and through CY 2021. As such, the extreme and uncontrollable circumstances policy will be available for the 2021 performance period.

**Remember:** if a clinician, group, or virtual group submits data for the 2021 performance period, the data submission overrides the application and the clinician, group, or virtual group will be scored on the data submitted.

## How are MIPS "ineligible" clinicians affected by MACRA?

*Revenue*

A clinician who is not eligible to participate in MIPS is not subject to MIPS payment adjustments — good or bad. However, clinicians who voluntarily report data will receive a feedback report from CMS, allowing them to see how their performance may affect future payments.

*Marketing*

CMS allows a 30-day "opt-out" period for low-volume eligible clinicians to voluntarily submit data and not have the information become public. Unfortunately, they will not know how they did and whether they should opt out for several months later, when CMS releases performance feedback.

## How are MIPS eligible clinicians affected?

*Marketing*

CMS will publish MIPS eligible clinicians' performance scores on its Physician Compare website[11]. This free website is used by patients and consumer rating websites. Exceptional performers will benefit from this free advertising. The same cannot be said for underperformers.

CMS will publish final scores a year after data is reported, giving clinicians time to preview their performance data and, if appropriate, request a targeted review before it is made public. Clinicians will be rated on a scale of 0 to 100 and how they compare to peers nationally. A 2014 JAMA study found that 65 percent of consumers are aware of online physician rating sites and 36 percent of consumers have used a ratings site at least once. High performance scores and ratings can become a strategic marketing advantage for providers over their competitors who have low or no scores.

*Future Options to Join a Group*

If a clinician's MIPS performance feedback scores are low, their ability to join a new group or hospital may be compromised. Potential employers will not want to inherit a clinician's low score and risk lowering their score.

*Revenue*

Both tracks in the QPP have levels of financial risks and rewards.

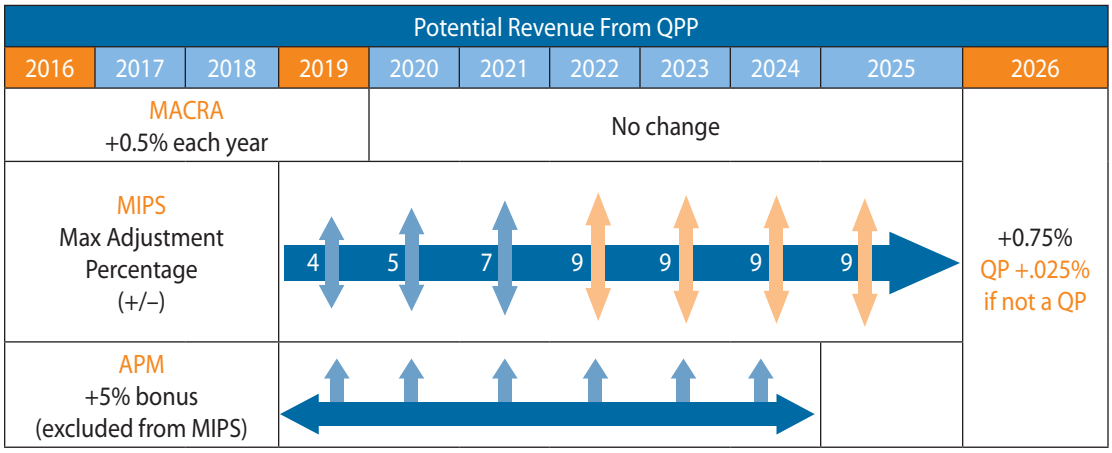
11 www.medicare.gov/physiciancompare/

# Payment Adjustments and Bonus Options

The timeline for QPP performance and payment adjustments spans three years. For example:

| Performance Year | Submission/Feedback Year | Payment Year |
|---|---|---|
| 2020 | 2021 | 2022 |

Clinicians collect data during the performance year; submit the data to CMS between January 1 and March 31 the following year, receive performance feedback by July that year; and receive payment adjustments based on performance the following year. Scheduled MIPS payment adjustments and potential bonuses for Qualifying APM Participants (QP) and Partial Qualifying APM Participants (PQP) in an Advanced APM are shown in the table below.




When a clinician has multiple final scores associated with a single TIN/NPI combination, CMS will use a virtual group final score first to determine the 2023 payment year MIPS payment adjustment and the highest available final score from the APM entity, group, or individual second. This is changed from 2022 payment year policy, in which the APM entity final score will be considered first.

## Performance Threshold

To receive a neutral payment adjustment to Medicare Part B claims in 2023, MIPS eligible clinicians will need to earn a final score of 60 points, the performance threshold for year 5. This is a change from the 45-point threshold in year 4. The additional performance threshold for exceptional performance is 85 points (up from 80 points in 2020). Note, however, that year 4 was the final year for additional positive adjustments for exceptional performance. (Scoring is discussed in Chapter 11.)

### Budget Neutral

MIPS is budget neutral, which means CMS takes the money it saves from providers who receive reductions to pay for provider who receive increases. The maximum upward adjustment is capped at three times the maximum negative adjustment.

### Bonus Points

CMS discontinued awarding measure bonus points to CMS Web Interface reporters for reporting high priority measures in performance year 2019. Beginning in 2019 and through the 2023 MIPS payment year, the total measure bonus points for high priority measures cannot exceed 10 percent of the total available measure achievement points.

Beginning with payment year 2023, bonus points for the Query of Prescription Drug Monitoring Programs (PDMP) measure are increased from 5 points to 10 points, based on 2021 performance.

## Complex Patient Bonus

CMS will apply a complex patient bonus capped at 5 points to the final score for the 2021 MIPS performance period/2023 MIPS payment year. Complexity is measured through hierarchical condition category (HCC) risk scores and social risk as measured through the proportion of patients with dual eligible status.

HCC risk scores are calculated annually, based on the following information from the calendar year:

- Patient's age and gender;
- Patient's eligibility for Medicaid, disabled, or lives in an institution; and
- Patient's diagnoses.

The formulas used to calculate the bonuses are:

- MIPS eligible participants:

  [the average HCC risk score assigned to beneficiaries seen by the MIPS eligible clinician or seen by clinicians in a group] + [the dual eligible ratio x 5].

- APM entities:

  [the beneficiary weighted average HCC risk score for all MIPS eligible clinicians, and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation within the APM entity or virtual group, respectively] + [the average dual eligible ratio for all MIPS eligible clinicians, and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation, within the APM entity or virtual group, respectively, x 5].

**Note:** The QPP is budget neutral so all figures are variable, depending on the number of providers sharing the $500 million MACRA provided for this purpose.

Chapter 4

# Small Practices

Small practices face challenges in their ability to participate in MIPS. CMS encourages small practices to participate by subsidizing some of their infrastructure hurdles. CMS states in the 2018 QPP final rule, "The support of small, independent practices remains an important thematic objective for the implementation of the Quality Payment Program and is expected to be carried throughout future rulemaking." CMS defines small practices for the purposes of MIPS as 15 or fewer clinicians.

Is in previous years, CMS continues to award 6 bonus points in the Quality performance category to MIPS eligible clinicians in small practices who submit data on at least one measure and 3 points for quality measures that don't meet data completeness requirements. Additionally, clinicians in small practices may apply to have the Promoting Interoperability performance category reweighted to zero. Small practices also have reduced reporting requirements in the Improvement Activities category:

- Medium-weighted activities are worth 20 points; and
- High-weighted activities are worth 40 points

CMS also offers free and customized resources available within local communities, including direct, one-on-one support from the Small, Underserved, and Rural Support Initiative, in addition to CMS' other no-cost technical assistance.

Beginning with the 2019 performance period (year 3), only small practices — whether participating individually or as a group — may submit quality measures using Medicare Part B claims as a submission type.

Lastly, small practices may continue to participate in MIPS as a virtual group.

## Virtual Groups

Beginning with the 2019 performance period, clinicians may participate in MIPS as an individual, as a group, as an APM entity in a MIPS APM, or as a virtual group.

A virtual group is a combination of two or more TINs assigned to one or more solo practitioners or one or more groups consisting of 10 or fewer eligible clinicians that elect to form a virtual group for a performance period for a year.

If a group chooses to join a virtual group, all of the clinicians in that group are part of the virtual group. The group's final score and resulting payment adjustment percentage applies to all clinicians in the virtual group.

The virtual group eligibility determination period aligns with the first period of data analysis under the MIPS eligibility determination period. For year 5, the determination period is Oct. 1, 2019, to Sept. 30, 2020 (including a 30-day claims run out).

### Eligibility

A virtual group election is considered a low-volume threshold opt-in for any prospective member of the virtual group that exceeds at least one, but not all three, of the low-volume threshold criteria. Clinicians can only participate in one virtual group per performance period.

There is no limit on the size of a virtual group[12].

Virtual groups are held to the same requirements for each performance category as standard groups, and are responsible for aggregating data for their measures and activities across the virtual group.

TINs can inquire about their TIN size prior to making an election during a 3-month time frame, which begins Oct. 1 and ends Dec. 31 of the calendar year prior to the applicable performance period.

### Election Process

There is a two-stage election process for virtual groups:

Stage 1 (optional): If you're a solo practitioner or part of a group with 10 or fewer eligible clinicians:

- Make any formal written agreements.
- Send in your formal election registration.
- Budget your resources for your virtual group.

Stage 2 (required): The virtual group must have a formal agreement between each solo practitioner and group that composes the virtual group prior to submitting an election to CMS. Each virtual group must name an official representative who is responsible for submitting the virtual group's election. Elections must be submitted via e-mail to MIPS_VirtualGroups@cms.hhs.gov by December 31 of the preceding year you intend to operate as a virtual group.

The data submission criteria applicable to groups are also generally applicable to virtual groups, except for data completeness and sampling requirements for the CMS Web Interface and CAHPS for MIPS survey:

12 42 CFR Part 414 § II.C.4

- Data completeness for virtual groups applies cumulatively across all TINs in a virtual group. There may be a case when a virtual group has one TIN that falls below the 60 percent data completeness threshold, which is an acceptable case as long as the virtual group cumulatively exceeds such threshold.
- The CMS Web Interface and CAHPS for MIPS survey sampling requirements pertain to Medicare Part B patients with respect to all TINs in a virtual group, where the sampling methodology will be conducted for each TIN within the virtual group and then cumulatively aggregated across the virtual group. A virtual group would need to meet the beneficiary sampling threshold cumulatively as a virtual group[13].

For more information, view the Virtual Groups Toolkit at https://qpp.cms.gov/.

13 CMS, "Quality Payment Program: Overview of Virtual Groups" webinar; https://qpp.cms.gov/about/help-and-support

Chapter 5

# Alternate Payment Models

An Alternate Payment Model (APM) is a payment approach that gives clinicians added incentive payments for providing high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. There are several alternate payment approaches that provide added incentives and downside risk to clinicians related to cost efficient care, which qualify as an APM.

For example:

- Pay-for-Performance
- Bundled Payment
- Shared Savings Programs
- Accountable Care Organizations (ACO)
- Patient Centered Medical Homes

### Advanced APM Model

Advanced APMs are CMS approved subsets of APMs that have met specific criteria. Approved models are listed at: https://qpp.cms.gov/apms/overview.

Advanced APMs must require participants to:

1. Use CEHRT (at least 75 percent of the entity's eligible clinicians must use CEHRT.
2. Provide payment for covered professional services based on quality measures comparable to those used in the MIPS Quality performance category (including at least one outcome measure, if applicable); and
3. Either be a Medical Home Model expanded under CMS Innovation Center authority or require participants to bear a significant financial risk.

Advanced APM entities must accept financial risk that their actual expenditures for patient care do not exceed expected expenditures. An Advanced APM entity may accomplish this by withholding provider payments, reducing provider rates, or paying CMS back. The Medical Home Model includes risk of 2.5 percent of Medicare Parts A and B revenue. All other models are 8 percent of the estimated average total Medicare Part A and B revenues of participating APM entities, or 3 percent of the expected expenditures for which an APM entity is responsible under the APM.


Advanced APMs require applications for participation to be submitted before the start of a performance year. Most APMs entities allow clinicians to join throughout the year. It is important to understand the existing regulations for the APM the clinician will be joining.

## APM Entities

APM entities[14] are organizations that participate with the Advanced APM or other APMs. Clinicians and their associated tax IDs (TINs) may join an existing APM entity or create a new APM entity (but must adhere to application deadlines, which can be annually or every several years). An APM entity is a group of eligible clinicians participating in an APM, as identified by a combination of the APM identifier, APM entity identifier, TIN, and NPI for each participating eligible clinician.

## Participating Providers

Advanced APM participating providers are eligible clinicians and clinician groups that have applied and been accepted to participate in a qualified Advanced APM. Actuarial reviewed data is suggested before making the decision to minimize unexpected risks.

CMS recognizes clinicians as Qualifying APM Participants (QPs) if they appear on the Provider List Snapshot, reviewed on March 31, June 30, August 31, and for Medicare Shared Savings Program participants, December 31. Clinicians who are not participating in an APM during these snapshots must submit data to MIPS using the MIPS individual/group option to avoid a negative payment adjustment. MIPS APM special scoring may apply.

Beginning in 2019, CMS allows for QP determinations under the All-Payer Option to be requested at the TIN level, in addition to the APM entity and individual eligible clinician levels, when all eligible clinicians who have reassigned their billing rights to the TIN are included in a single APM entity.

The All-Payer Combination Option allows eligible clinicians to become QPs by meeting the QP payment amount or patient count threshold through a pair of calculations that assesses

14 https://www.law.cornell.edu/cfr/text/42/414.1305

a combination of both Medicare Part B covered professional services furnished through Advanced APMs and services furnished through Other Payer Advanced APMs.

### QP Payment Amount Thresholds—All-Payer Combination Option

| Payment Year | 2021 | 2022 | 2023 2025 |
|---|---|---|---|
| **QP Payment Amount Threshold** | | | |
| Medicare Minimum | 25% | 25% | 25% |
| Total | 50% | 50% | 50% |
| **Partial QP Payment Amount Threshold** | | | |
| Medicare Minimum | 20% | 20% | 20% |
| Total | 40% | 40% | 40% |

### QP Patient Count Thresholds—All-Payer Combination Option

| Payment Year | 2021 | 2022 | 2023 2025 |
|---|---|---|---|
| **QP Patient Count Threshold** | | | |
| Medicare Minimum | 20% | 20% | 20% |
| Total | 35% | 35% | 35% |
| **Partial QP Patient Count Threshold** | | | |
| Medicare Minimum | 10% | 10% | 10% |
| Total | 25% | 25% | 25% |

## Attributable Beneficiaries

Scores are based on how many patients are attributed to the APM entity versus attributable beneficiaries. Attributable beneficiaries are the universe of beneficiaries that could be attributed to the APM entity. These are patients who are: (1) not enrolled in HCC MA or a Medicare cost plan; (2) do not have MSP; (3) are enrolled in both Parts A and B; (4) are at least 18 years of age; (5) are U.S. residents; and (6) have a minimum of one E/M visit or other qualified service under the rules of the APM.

Physicians within the entity are incentivized to see patients more frequently who are attributed to them. APMs may have different rules on what constitutes a patient as attributed to an individual provider.

The definition of attribution is complicated because the same beneficiary may be attributable for multiple eligible clinicians. For example, a patient who sees one physician for one problem and then another physician for a different problem could create confusion regarding who the patient officially belongs to on the attribution list. Nonetheless, APM entities have officially accepted the responsibility of cost and quality of care for the patients on their attribution list.

CMS finalized for the 2021 QP performance period, that Medicare patients who have been attributed to an APM entity during a QP performance period will not be attributable Medicare patients for any APM entity that is participating in an APM that doesn't allow such attributed Medicare patients to be attributed to another APM entity.

MIPS eligible clinicians can check their QP status using the QPP Participation Status Tool at qpp.cms.gov (EIDM credentials required). New for performance year 2021, CMS will accept targeted review requests for QP determinations under limited circumstances.

## Qualifying APM Participants (QP) for the 5% Bonus

As a QP, an eligible clinician is not subject to the MIPS reporting requirements and payment adjustment, and qualifies for a lump sum APM incentive payment equal to 5 percent of "the paid amount of the applicable claims for covered professional services that are subsequently aggregated to calculate the estimated aggregate payments," CMS clarifies in the 2021 QPP final rule.

Contrary to what CMS finalized in the 2021 MPFS final rule, the Consolidated Appropriations Bill of 2020 put a temporary freeze on the APM payment incentive thresholds, keeping them at 2020 levels for two more years (2021 and 2022). To achieve QP status in 2021, clinicians must receive at least 50 percent of Medicare Part B payments OR see at least 35 percent of Medicare patients through an Advanced APM entity.

The QP performance period is Jan. 1, 2021 – Aug. 31, 2021. During this period, CMS will take three snapshots to assess performance: March 31, June 30, and Aug. 31. QP determination is made approximately four months after the end of each snapshot date to allow for 60 days of claims run-out. The QP incentive payment base period is Jan. 1, 2022 – Dec. 31, 2022. Eligible clinicians who achieve QP status in 2021 will receive a 5 percent lump sum payment in 2023.

## Partial Qualified Participants - No Bonus

PQPs have the option to report under MIPS. If they do, they will be given extra MIPS APM credit in their scores, but no QP bonus. To achieve PQP status in 2021, clinicians must receive at least 40 percent of Medicare Part B payments OR see at least 25 percent of Medicare patients through an Advanced APM entity.

CMS estimated that for the 2021 QP performance period, between 196,000 and 252,000 eligible clinicians would become QPs. That number will probably be much higher due to the APM threshold freeze.

# MIPS - Overview

There are four performance categories in MIPS, linked by their connection to quality and value of patient care. In most cases, eligible clinicians are scored in all four categories and a MIPS composite, or final, score determines their Medicare Part B payment adjustments. Year 5 performance categories and weights in the final score are:[15]

| Quality | Cost | Promoting Interoperability | Improvement Activities |
|---|---|---|---|
| 40 | 20 | 25 | 15 |

Although the Quality performance category started out as the heavy hitter in MIPS, by payment year 2024, it must be evenly weighted with the Cost performance category, per MACRA.

| | Quality | Promoting Interoperability | Improvement Activities | Cost |
|---|---|---|---|---|
| PYMT YR 2019 | 60% | 25% | 15% | 0% |
| PYMT YR 2020 | 50% | 25% | 15% | 10% |
| PYMT YR 2021 | 45% | 25% | 15% | 15% |
| PYMT YR 2022 | 45% | 25% | 15% | 15% |
| PYMT YR 2023 | 40% | 25% | 15% | 20% |
| PYMT YR 2024 | 30% | 25% | 15% | 30% |

These weights do not apply to the APP. Performance category weights for APM entities reporting traditional MIPS for the 2021 performance period is as follows:

- Quality: 50%
- Cost: 0%
- Promoting Interoperability: 30%
- Improvement Activities: 20%

## Individual Versus Group Reporting

Eligible clinicians can choose to report as a group or individually. If clinicians collectively submit their MIPS data as a group, each eligible clinician in the group will receive the same payment adjustment based on the group's final score. Groups are defined by a single TIN; whereas, individuals are defined at the TIN/NPI level. Beginning with performance year 2018, CMS will treat virtual groups (discussed in Chapter 4) as standard groups.

### Data Submission

There are several methods for reporting MIPS performance data. Groups have options not available to individual reporters and vice versa. Quality measures also dictate submission methods.

Individual MIPS Data Submission Options:

- Medicare Part B claims– Quality – Add Quality Data Codes (QDCs) to denominator-eligible claims.
- Qualified Clinical Data Registry (QCDR) – Quality, Improvement Activities, Promoting Interoperability – Specialty associations approved to offer additional quality measures. Contact the association for the cost.
- MIPS Clinical Quality Measures (CQM)
- eCQM (electronic CQM)
- 2015 Edition Certified Electronic Health Record Technology (CEHRT) – Quality, Improvement Activities, Promoting Interoperability – Similar to 2016 PQRS and Meaningful Use (MU) reporting.

Group Reporting Options (including Virtual Groups):

- QCDR – Quality, Improvement Activities, Promoting Interoperability – Specialty associations approved to offer additional quality measures. Contact the association for cost.
- MIPS CQM/eCQM – Quality, Improvement Activities, Promoting Interoperability.
- CEHRT Edition 2015 – Quality, Improvement Activities, Promoting Interoperability – Similar to 2016 PQRS and MU reporting.
- Medicare Part B claims measures
- CMS Web Interface - (groups with 25 or more clinicians) – Quality – To submit Quality measures data through this mechanism, your group must register by June 30 of the performance year. Note: The CMS Web Interface will sunset with the 2022 performance period. For 2021, groups and virtual groups may use this as a collection type and submission type.

15 https://qpp.cms.gov/about/resource-library

- Administrative claims – Cost performance categories are evaluated using data submitted through routine billing. No data submission is required.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey – Quality – CMS-approved survey vendor that collects and submits data about the experience of care at the practice on behalf of the group.

There are a number of ways a clinician can reach the 60-point threshold in 2021. Remember: Small practices already have a 6-point lead; and the complex patient bonus is worth up to an additional 5 points. CMS gives these examples for how to reach the threshold:

- Report all required Improvement Activities measures;
- Meet the Promoting Interoperability base score and submit one quality measure that meets data completeness;
- Meet the Promoting Interoperability base score by reporting the five base measures, and submit one medium-weighted improvement activity; or
- Submit six quality measures that meet data completeness criteria.

IMPORTANT NOTE IF YOU ARE SUBMITING DATA VIA CLAIMS: You will be able to tell if your quality reporting data has been accepted when you see the remittance advice from Medicare code N620. However, this code doesn't tell you that the code was appropriate — just that it was received. This reporting option is only available to individuals, not to groups or virtual groups.

For year 5, the second 12-month segment of the MIPS determination period (Oct. 1, 2020, to Sept. 30, 2021, will be used when calculating average HCC risk scores and the proportion of full benefit or partial benefit dual eligible beneficiaries for MIPS eligible clinicians.

Note these newer terms:

**Collection Type:** A set of quality measures with comparable specifications and data completeness criteria (e.g., claims measures, registry measures, etc.). CMS revised this definition for year 5 to remove CMS Web Interface as of year 6.

**Submitter Type**: The entity participating in MIPS

**Submission Type:** The mechanism by which the submitter type submits data to CMS, including: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface. CMS revised this definition for year 5 to remove CMS Web Interface as of year 6.

## MIPS Value Pathways

CMS finalized a MIPS Value Pathways (MVP) framework in the 2020 QPP final rule with the intention of implementing it beginning with the 2021 performance period. Due to the COVID-19 pandemic, CMS is waiting until at least 2022 to implement MVPs.

The MVP framework will connect measures and activities across the four MIPS performance categories, incorporate a set of administrative claims-based quality measures that focus on population health, provide data and feedback to clinicians, and enhance information provided to patients.

Once implemented, MVPs will wholly change the MIPS program, including the way in which MIPS eligible clinicians are scored. CMS anticipates that they will be able to score quality measures from 1 to 10 for measures in MVPs and, as such, will revisit and possibly remove the 3-point floor for traditional MIPS in future years.

For more information, download the MIPS Value Pathways Diagrams from https://qpp.cms.gov/about/resource-library.

# MIPS - Quality

The Quality component of MIPS is similar to the Physician Quality Reporting System (PQRS). This continues to be the highest weighted performance category in MIPS, worth at least 40 percent of a clinician/group's MIPS final score in year 5 (performance year 2021/payment year 2023).

## Data Completeness

In performance year 2017, data completeness was 50 percent of patients that meet the measure's denominator criteria, regardless of payer. For performance years 2018 and 2019, a clinician had to successfully submit 60 percent (for Part B claims, QCDR measures, MIPS CQMs, and eCQMs) of all eligible encounters to meet data completeness criteria. For years 4 and 5, the data completeness threshold is 70 percent. (Administrative claims measures, CMS Web Interface measures, and the CAHPS for MIPS survey measure have different data completeness requirements.) If a measure's criteria are not met, the clinician could earn as little as 1 point (3 points for small practices) for a measure.

Beginning with performance year 3, the Quality denominator will be reduced by 10 and the measure will receive 0 points for groups that submit five or fewer quality measures and do not meet the CAHPS for MIPS sampling requirements.

To determine the number of encounters a clinician needs to submit to meet a measure's data completeness criteria:

1. Choose measures applicable to the practice.
2. Determine the eligible populations, per measure specifications such as demographics and codes.
3 Verify reporting frequency, per measure specifications, and multiply it by the determined population (this is your eligible instances).
4. Divide your eligible instances by 60 percent to learn your minimum number of submissions to meet data completeness.

## Quality Performance Category Reporting Requirements

To achieve the highest score in this category (60 points), clinicians will need to report on at least six quality measures, including at least one outcome measure or high-priority measure. Beginning in 2019, clinicians must now collect a full calendar year of data.

For 2021, there are over 209 measures to choose from. Changes include removal of 11 quality measures, including the All-Cause Hospital Readmission measure and the addition of two new administrative claims quality measures:

- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups
  - This measure has a 200-case minimum; 1-year measurement period; and only applies to groups, virtual groups, and APM entities with 16 or more clinicians that meet the case minimum.
- Risk-Standardized Complication Rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-Based Incentive Payment System (MIPS) Eligible Clinicians
  - This measure has a 25-case minimum; a 3-year measurement period; and applies to individual clinicians, groups, and virtual groups that meet the case minimum.

**See Appendix 2 in this training for a list of high-priority quality measures.**

Review the entire list of quality measures at:
https://qpp.cms.gov/mips/quality-measures

## Specialty Set Measures

Providers are not required to select measures listed in the specialty set that applies to them. It is, however, a tool that could help them select measures that most likely apply to them. Keep in mind: Measures should ultimately be selected by how a provider's performance with a measure compares with the benchmarks for that measure, and if they have at least 20 cases to submit. If there are no outcome measures applicable to your practice, chose another high-priority measure.

MIPS eligible clinicians should refer to the measures specifications to verify which measures are applicable. Not all measures in each specialty measure set will be applicable to all clinicians in each specialty. If the set includes less than six applicable measures, the eligible clinician should only report the measures that are applicable. If a provider or group selects a measure and sees less than 20 eligible patients, only the minimum score can be earned.

Specialties include:

- Allergy/Immunology
- Anesthesiology
- Cardiology
- Dermatology
- Diagnostic Radiology
- Electrophysiology Cardiac Specialist
- Emergency Medicine
- Gastroenterology
- General Oncology
- General Practice/Family Medicine
- General Surgery
- Hospitalists
- Internal Medicine
- Interventional Radiology
- Mental/Behavioral Health
- Neurology
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine
- Plastic Surgery
- Preventive Medicine
- Radiation Oncology
- Rheumatology
- Thoracic Surgery
- Urology
- Vascular Surgery

These specialty sets will be replaced with MIPS Value Pathways (MVPs) as early as 2022.

## Topped Out Measures

A measure becomes topped out if the meaningful distinctions and improvement in performance can no longer be made. These measures could have an impact on the scores for certain MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians. These measures will be identified in each final rule, if a measure is identified for three consecutive years, it will be eliminated in the fourth year. Topped out measures are capped at 7 points. (This does not apply to the CMS Web Interface measures.)

There are no changes to topped out measures in the 2021 QPP final rule.

## MIPS Scoring – QUALITY

CMS converts each measure into a 10-point scoring system. Each measure is then broken down into 10 "deciles," with each decile reflecting 1 to 1.9 points. The deciles will be based upon layers of national performance within that baseline period.

The Quality performance category score is calculated by comparing a provider's performance to a national benchmark. Below is an example of what a benchmark could look like.

Selected quality measures will be expressed as a percentage performance rate. For example: A provider who reports on measure **226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention** using codes 1036F and 4004F for 600 office visits out of a total of 800 would have a reporting score of 75 percent, which meets the criteria of 60 percent. If 500 of the 600 cases are accepted as meeting the performance measure (500 did not include modifier P1 or P8) the performance rate is calculated as 500/600 or 83.3 percent, which falls into the 9th decile.

Six measures are required for full compliance, each worth up to 10 points; therefore, the maximum quality score is 70 points. The MIPS Quality score is worth 40 percent of the overall MIPS final score. To calculate the quality component, the formula is:

**Total Points Earned / 60 = Percent of Quality Earned**
**Percent of Quality Earned x 40% x 100 = MIPS POINTS**

### Example 1

For example, a provider who reports one measure (with sufficient volume of 20+ cases and data completeness of 70 percent) and scores in the 8th decile would earn 6 points.

8/60 = 13.3%

13.3% x 40% x 100 = 5 MIPS points

Beginning with payment year 2022, for each measure that has the potential to result in inappropriate treatment, CMS will set benchmarks using a flat percentage for all collection types where the top decile is higher than 90 percent under the performance-based benchmarking methodology.

For the 2020 performance period, CMS established scoring flexibilities for quality measures — truncating the performance

period of measures with significant ICD-10 coding changes to the first nine months of the calendar year and suppressing measures with significant changes to clinical practice guidelines from scoring (0 achievement points and total measure achievement points reduced by 10).

CMS expands on these flexibilities in 2021 by expanding the list of reasons that a quality measure may be impacted during the performance period, and basing performance on such measures on data for nine consecutive months of the performance period. If no data is available or may result in patient harm or misleading results, CMS will suppress the measure.

## Collection Types

Collection types for MIPS eligible clinicians reporting as individuals include:

- eCQMs
- MIPS CQMs
- QCDR measures
- Medicare Part B claims (small practices only)

Collection types for MIPS eligible clinicians reporting as groups include:

- eCQMs
- MIPS CQMs
- QCDR measures
- Medicare Part B claims (small practices only)
- CMS approved survey vendor measure
- Administrative claims measures

## Submission Types

Data submission types for MIPS eligible clinicians reporting as individuals include:

- Direct
- Log in to QPP and upload
- Medicare Part B claims (small practices only)

Data submission types for MIPS eligible clinicians reporting as groups include:

- Direct
- Log in and upload
- CMS Web Interface (groups with 25+ eligible clinicians)
- Medicare Part B claims (small practices only)

**Note:** Medicare Part B claims require certain billing codes appended to denominator-eligible Medicare Part B claims to indicate the required quality action or exclusion occurred.

In year 5, Cost will be calculated at 20 percent of the MIPS final score. The weight for this performance category will increase to 30 percent of the MIPS final score for year 6 (performance year 2022/payment year 2024), as required by MACRA.

Cost is based on resource use. CMS will use normalized costs across the country by eliminating regional wage indices, as well as removing disproportionate share payments and medical education costs from hospital and facility fees. This allows CMS to measure the number and intensity of services, tests, and treatments provided to beneficiaries. The result is expressed in dollars compared to expected expenditures nationally for each measure.

There were no changes to the 2020 measure methodology. The Cost performance category measures for 2021 performance year are:

- Total per Capita Cost measure
- Medicare Spending per Beneficiary Clinician (MSPB-C)
- 18 existing episode-based measures

CMS is adding telehealth services directly applicable to existing episode-based code measures and the TPCC measure.

Data is collected through administrative claims data; clinicians do not need to submit any further data for calculation. All claims have trigger codes, which CMS uses to decide if a case falls in or out of a given formula. For Cost measures, the calculation includes those patients that CMS attributes to the clinician.

**Total Per Capita Cost (TPCC):** This formula looks at the overall cost of a patient's care for both Medicare Parts A and B for a given year. Total per Capita Cost measures the total yearly costs for all patients assigned to a provider, divided by the total number of patients assigned to that provider. Beginning in 2020, TPCC attribution requires E/M services to have an associated primary care service or a follow-up E/M service from the same clinician group. TPCC attribution excludes certain clinicians who primarily deliver certain non-primary care services. The clinician must have at least 20 cases r for the measure to be applicable.

**Medicare Spending Per Beneficiary Clinician (MSPB-C):** This resource use measure is triggered by acute care episodes related to hospitalizations. The measure includes all Parts A and B payments beginning two days prior to hospitalization and lasting for 30 days following hospitalization. The clinician must have at least 35 cases for the measure to be applicable.

Cost measures are available for download at https://qpp.cms.gov/mips/cost.

## Episode-Based Cost Measures

These measures are based on services provided to a patient during a particular episode of care. Eight episode-based Cost measures were added in year 3. CMS advises providers to access and review their field test reports to gain understanding.

Attribution for episode-based measures:[16]

Patients are attributed to a clinician's claims submission information. CMS gives the following examples in the *Merit-Based Incentive Payment System (MIPS): Episode-Based Cost Measure Field Test Reports* (October 2017) Frequently Asked Questions (FAQs):

- The attributed clinician is identified by unique Taxpayer Identification Number/National Provider Identifier (TIN-NPI) informed by the performing NPI field on the physician/supplier Part B (carrier) claim.
- For procedural episode groups, episodes are attributed to the clinician(s) rendering the trigger services (HCPCS/CPT® procedure codes).
  - For example, an orthopedic surgeon billing CPT® code 27446 would be attributed a knee arthroplasty episode.
- For acute inpatient medical condition episode groups, episodes are attributed to the clinician(s) rendering at least 30 percent of inpatient evaluation and management (E/M) services during an inpatient hospitalization with the medical Medicare Severity Diagnosis Related Groups (MS-DRGs) for the episode group.
  - For example, a neurologist billing 30 percent of inpatient E/M codes on Part B physician/supplier claims concurrent to an inpatient hospitalization with MS-DRG code 065 would be attributed an intracranial hemorrhage or cerebral infarction episode.

In some cases, the cost of care may be attributed to more than one physician. The use of patient relationship codes ensures the attribution of patients and care episodes to clinicians who serve patients in different roles. Patient relationship codes

16 https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Cost-Measures-Field-Test-FAQs.pdf

distinguish the relationship and responsibility of a clinician with a patient at the time of service. To ensure CMS properly attributes Cost measures, MIPS eligible clinicians should append the following HCPCS Level II modifiers to procedure codes, as applicable:

X1 Continuous/Broad Services

X2 Continuous/Focused Services

X3 Episodic/Broad Services

X4 Episodic/Focused Services

X5 Only as ordered by another clinician

There is a case minimum of 10 for procedural episodes and a case minimum of 20 for acute inpatient medical condition episodes.

For procedural episodes, CMS will attribute episodes to each MIPS eligible clinician who renders a trigger service (identified by procedure codes).

For acute inpatient medical condition episodes, CMS will attribute episodes to each MIPS eligible clinician who bills inpatient E/M claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30 percent of the inpatient E/M claim lines in that hospitalization.

A couple of notes about the Cost performance category:

- If only one performance category can be scored, it will serve as the performance category score. If there is insufficient data to score Cost, CMS will assign 0 percent.
- There is no improvement scoring as of year 3.

## Facility-Based Quality and Cost Performance Measures

New in year 3, the election to report facility-based quality and cost measures automatically applies to MIPS eligible clinicians and groups who would benefit by having a higher combined Quality and Cost performance category score.

There are no data submission requirements for the Quality and Cost performance categories for individual clinicians and groups in facility-based measurement.

### Who Qualifies?

Individual MIPS eligible clinicians who furnish 75 percent or more of their covered professional services in an inpatient hospital (Place of Service code 21), on-campus outpatient hospital (22), or emergency room (ER) (23), based on claims for a period prior to the performance period.

Clinicians are required to have at least a single service billed with an inpatient hospital or ER POS code.

A facility-based clinician is attributed to the hospital at which they provide services to the most Medicare patients, or the value-based purchasing score for the highest scoring facility. If CMS is unable to attribute a clinician's performance, that clinician must participate in MIPS using a different method.

An individual or group must submit data in the Improvement Activities or Promoting Interoperability performance categories to be scored under facility-based measurement.

The Cost performance category percent score formula is:

**# of points assigned to the measure (based on performance, compared to single, national benchmark) /**
**# of total possible Cost achievement points available x 100**
**= Cost performance category percent score**

Chapter 9

# MIPS - Promoting Interoperability

Promoting Interoperability replaced Meaningful Use to continue the effort for secure exchange of health information and the use of certified EHR technology (CEHRT). For most providers, this category is worth 25 percent of the MIPS final score. In some cases, a provider may qualify for a hardship exception from this performance category. In these circumstances, the Promoting Interoperability performance category is reassigned a weight of 0 percent and the Quality performance category is increased from 40 percent to 65 percent.

In year 4 and beyond, there is no bonus for meeting the 2015 CEHRT requirement. For performance years 2020-2022, MIPS eligible clinicians may use 2015 Edition CEHRT, 2015 Edition Cures Update certification criteria, or a combination of both.

The objectives and measures for 2021 performance are:

- Health Information Exchange (HIE)
  - A new, optional HIE bidirectional exchange measure is added.
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange
- ePrescribing (10 pts)
- Query of Prescription Drug Monitoring Program (PDMP) (10 bonus pts) (optional)
- Support Electronic Referral Loops by Receiving and Reconciling Health Information

Clinicians are required to report certain measures from each of the four objectives, unless an exclusion is claimed.

MIPS eligible clinicians who may qualify for an automatic exception from this category include:

- "Hospital-based" clinicians (those with 75 percent or more of their Medicare encounters occurring in place of service 21 (hospital), 22 (on-campus outpatient hospital), or 23 emergency room)
- "Non-patient facing" clinicians (those who don't typically see patients face-to-face (e.g., radiology, anesthesiology) who bill fewer than 100 patient-facing CPT® codes to Medicare in a 12-month period). CMS has provided a list of the patient-facing CPT® codes at www.qpp.cms.gov. If reporting as a group, at least 75 percent of the eligible clinicians in the group must meet the non-patient facing criteria[17].
- Mid-level providers who are in their first year as a MIPS eligible clinician (see Chapter 2).

## Significant Hardship Exceptions

Hardship exceptions require an application and are evaluated on a case-by-case basis by CMS. Examples include natural disasters, lack of internet connectivity, EHR vendor issues, and lack of control over the EHR purchase and use.

A provider who is exempted from the Promoting Interoperability performance category may optionally choose to report data and will then be scored under the standard MIPS scoring formula. When reporting Promoting Interoperability as a group, CMS allows groups to exclude data for these exempted providers; however, all clinicians in the group will receive the shared MIPS final score.

## MIPS Scoring – Promoting Interoperability

CMS eliminated base, performance, and bonus scoring and finalized a new scoring methodology beginning with the 2020 performance year. Performance-based scoring is at the individual measure level. Each measure is scored based on the MIPS eligible clinician's submission of a numerator or denominator, or a yes or no response, where applicable. The scores for each of the individual measures are added together to calculate the score of up to 100 possible points. If exclusions are claimed, the points for measures are reallocated to other measures.

Automatic reweighting policies continue to apply for the following clinician types:

- Certified Registered Nurse Anesthetists (CRNA)
- Clinical Nurse Specialists (CNS)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Qualified Speech-Language Pathologists
- Qualified Audiologists
- Registered Dietitian or Nutrition Professionals

17 Face to Face code list: https://tinyurl.com/zl76pxa

## Promoting Interoperability Measures

Beginning in performance year 2019, the Security Risk Analysis measure is required, without points.

To explore the Promoting Interoperability measures, go to: https://qpp.cms.gov/mips/explore-measures/promoting-interoperability?py=2018#measures

## Data Submission Types

MIPS eligible clinicians/groups can use the following submission types for reporting in this performance category:

- Direct (end-to-end electronic reporting)
- Log in to the QPP and upload
- Log in to the QPP and attest

# MIPS - Improvement Activities

The Improvement Activities performance category focuses on care coordination, beneficiary engagement, and patient safety. For year 5, CMS is modifying two existing improvement activities; continuing the COVID-19 clinical data reporting improvement activity, which was added mid-year, with modification; and removing the CMS Partner in Patients Hospital Engagement Network improvement activity.

This category is worth 15 percent of the MIPS final score. To get full credit, a clinician/group must complete activities equal to a maximum 50 points or be a in a Patient-centered Medical Home, Medical Home Model, or similar specialty practice and a MIPS APM.

The scoring formula is:

**Total points for completed activities / 50 x 15**

Clinicians earn points with high-weighted activities worth 20 points each and medium-weighted activities worth 10 points each. Certain clinicians earn double-points for each improvement activity (high-weighted activities are worth 40 points and medium-weighted activities are worth 20 points):

- Small practices
- Providers in practices located in a rural area (in a ZIP code designated as rural in the most recent HRSA Area Health Resource File data set)
- Providers in practices located in a geographic Health Professional Shortage Area (HPSA)
- Non-patient-facing providers or groups

Patient-facing encounter codes determine non-patient facing status. A non-patient-facing MIPS eligible clinician is:

- An individual who bills 100 or fewer patient-facing encounters (including telehealth)
- A group with 75 percent of the clinicians billing under the group's TIN meeting the definition of a non-patient facing individual

The list of patient-facing encounter codes includes evaluation and management (E/M) codes and surgical and procedural codes.

A group or virtual group may attest to an improvement activity when at least 50 percent of MIPS eligible clinicians in the group participate in or perform the activity. At least 50 percent of the group's NPIs must perform the same activity for the same continuous 90 days in the performance period.

Because this performance category will be reported through attestation, it will be important for clinicians to maintain documentation that justifies their Yes/No statement that an activity was performed during the reporting period, in case of an audit.

**See Appendix 3: For a list of high- and medium-weighted activities.**

Download the latest MIPS Improvement Activities from https://qpp.cms.gov/mips/improvement-activities.

For the 2021 performance period, the Query of Prescription Drug Monitoring Program (PDMP) measure will remain optional, worth 10 bonus points. Also, the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information will be changed to Support Electronic Referral Loops by Receiving and Reconciling Health Information. Lastly, a new, optional Health Information Exchange (HIE) bidirectional exchange measure is added as an alternative to the two existing measures under the HIE objective.

## Data Submission Types

MIPS eligible clinicians/groups can use the following submission types for reporting in this performance category:

- Direct (end-to-end electronic reporting)
- Log in to the QPP and upload
- Log in to the QPP and attest

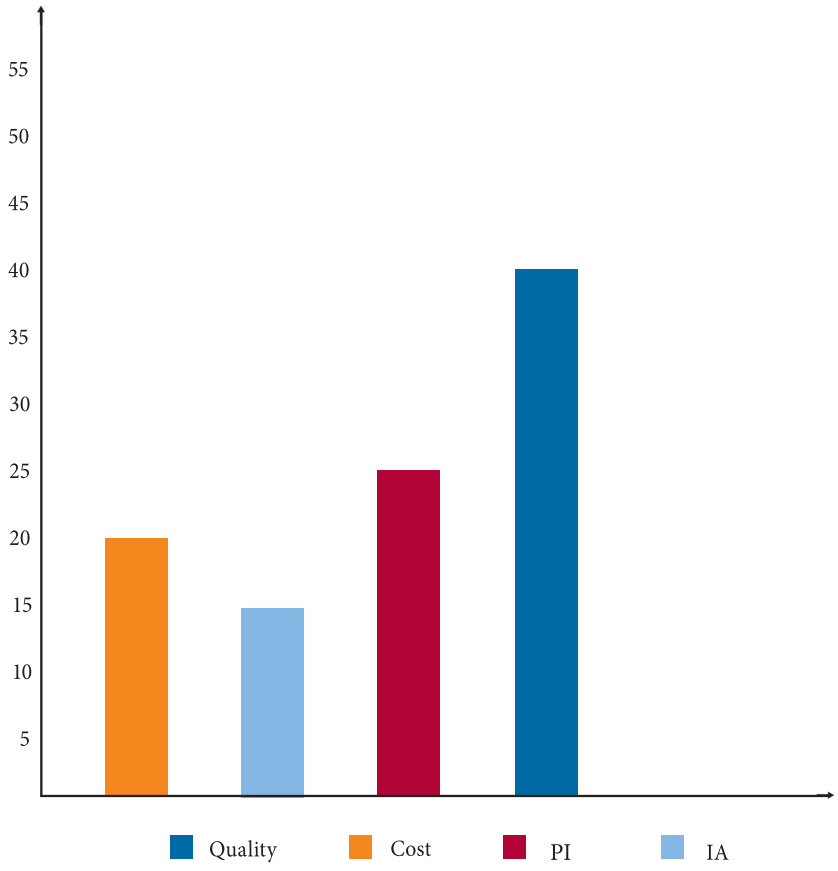
For the Promoting Interoperability performance category to be reweighted for a MIPS eligible clinician who elects to participate in MIPS as part of a group or virtual group, all of the MIPS eligible clinicians in the group must qualify for reweighting, or the group must meet the revised definition of a hospital-based MIPS eligible clinician or a non-patient facing MIPS eligible clinician.

# Calculating the MIPS Final Score

MIPS uses a unified scoring system that measures each performance category in points, which allows for partial credit. For example, a clinician who submits three out of the six required Quality measures will receive credit for the three measures submitted. Each performance category is assigned a weighted value to be compared with the points earned by the provider. The formula is:

**Quality score + Cost score + Improvement Activities score + Promoting Interoperability score + bonus points x 100 = MIPS Final Score**

## MIPS Category Weight



CMS estimates that MIPS payment adjustments will be approximately equally distributed between +/- 9 percent, which will ensure budget neutrality. Positive MIPS payment adjustments will also include an additional $500 million for exceptional performance payments to MIPS eligible clinicians whose performance meets or exceeds a threshold final score of 85 percent.

| Final Score Points 2021 | Payment Adjustment 2023 |
|---|---|
| ≥85.0-100 | • Greater than 0% on a linear scale<br>• Eligible for exceptional performance bonus — minimum of additional 0.5% |
| 60.01-84.99 | • Greater than 0% on a linear sliding scale<br>• Not eligible for exceptional performance bonus |
| 60.0 | • 0% |
| 15.01-59.99 | • Greater than negative 9% and less than 0% |
| 0-15.0 | • Negative 9% |

*Per Table 57 in 2021 MPFS Final Rule*

Chapter 12

# Calculating the Final Score Under MIPS APMs

Certain APMs include MIPS eligible clinicians as participants and hold these clinicians accountable for their cost and quality of care. CMS identifies these types of APMs as MIPS APMs. In prior years, MIPS APM participants received special MIPS scoring under the APM scoring standard. This is no longer the case beginning with performance year 2021.

In the 2021 QPP final rule, CMS finalized the APM Performance Pathway (APP). The APP, similar to MVPs, is a fixed set of measures for each MIPS performance category. In place of the MIPS APM scoring standard, CMS will use the following:

- Cost – 0%
- Improvement Activity – For year 5 only, all APM participants reporting the APP will be eligible to earn an Improvement Activities performance category score of 100%
- Promoting Interoperability – Same as MIPS

The APP has a quality measure set of three eCQM/MIPS CQM/Medicare Part B claims measures, a CAHPS for MIPS Survey measure, and two measures that will be calculated by CMS using administrative claims data. For performance year 2021 only, however, participants in accountable care organizations (ACOs) can continue to report the 10 CMS Web Interface measures in place of the three eCQM/MIPS CQM/Medicare Part B claims measures in the APP.

The APP is only available to MIPS eligible clinicians, groups, and APM entities participating in MIPS APMs and is required for Medicare Shared Savings Program accountable care organizations (ACOs).

Beginning in 2021, APM entities will not be evaluated for the low volume threshold. Clinicians in a MIPS APM will be evaluated for MIPS eligibility at the individual and group levels.

If an APM entity does not meet the QP threshold for the Advanced APM 5 percent lump sum bonus, but is listed as a participating provider, the clinician will be scored under MIPS.

An APM is considered a MIPS APM if it satisfies the following criteria:

1. APM entities must participate in the APM under an agreement with CMS or by law or regulations;
2. The APM must require that APM entities include at least one MIPS eligible clinician on a participation list;
3. The APM must base payment on quality measures and cost/utilization; and
4. The APM must be neither a new APM for which the first performance period begins after the first day of the MIPS performance year nor an APM in the final year of operation for which the APM scoring standard is impracticable.

It is possible for an APM to have tracks that are MIPS APMs and tracks that are not MIPS APMs.

There are 29 MIPS APMs but not all meet the requirements for the 2021 MIPS performance period. The following MIPS APMS have an effective start date in 2021, which makes them inedible for 2021 QP status:

- Direct Contracting (DC) Professional PBP Model
- Direct Contracting (DC) Global PBP Model
- Kidney Care Choices: Comprehensive Kidney Care Contracting (CKCC) Graduated Option Level 2
- Kidney Care Choices: Comprehensive Kidney Care Contracting (CKCC) Professional Option
- Kidney Care Choices: Comprehensive Kidney Care Contracting (CKCC) Global Option
- Kidney Care Choices: Comprehensive Kidney Care First (KCF)
- Primary Care First (PCF) General Option
- Primary Care First (PCF) Seriously Ill Population (SIP) Option
- Primary Care First (PCF) Seriously Ill Population (SIP) Option (non-CEHRT)
- Value in Opioid Use Disorder Treatment (ViT) Demonstration Program

Final CMS determinations of MIPS APMs can be found at qpp.com.gov.

# Tips for MACRA Compliance in 2021

Clinicians who have never reported on quality measures have a lot of catching up to do. Before jumping in headfirst:

- Determine if the clinician or clinician group qualifies for an exception or special accommodations in MIPS scoring.
- To minimize unexpected risks, have an actuary review the provider's data before making the decision to enter an APM agreement.
- Determine what your practice's goals are for the performance period.
- Calculate the associated costs for implementing MIPS compared to a potential MIPS payment adjustment. It is possible to earn a positive adjustment only to lose money due to implementation costs and supporting requirements. Consider long-term losses/gains for both scenarios.
- Providers who bill under more than one TIN should report their MIPS data through each group to earn bonuses.
- Enlist the services of a CPC® or other certified coder to audit medical documentation. It is essential to meet documentation requirements to support quality measures.
- Create a practice plan under MIPS. Determine who will conduct process development, strategic data analysis, training, and address underlying technology costs.
- Consider how your provider did in PQRS and Meaningful Use to estimate opportunity and risk in MIPS.
- Decide whether to report in MIPS as a group or individually. If you report as a group, all clinicians' data in the group is aggregated, so determine if reporting together improves your clinicians' MIPS final score.
- Determine a submission mechanism for MIPS quality data to CMS (i.e., claims, EHR, QCDR, etc.). The choice to report as an individual versus as a group impacts reporting and scoring options. Also, not all measures can be submitted via every available mechanism, so be sure to read each measure's specification document carefully.
- If you haven't adopted 2015 Edition CEHRT, explore the cost and opportunity.
- Determine if a provider's commercial payer contracts are tied to Medicare reimbursement rates and how this might financially impact the practice.
- Perform a security risk analysis that complies with HIPAA Security Rule requirements. This is a required measure under the Promoting Interoperability performance category.
- Review the quality measures and select those that apply to the provider's patient mix. The more measures you report on, the higher your chances of an increased score.
- Ensure your coder is a CPC® or AAPC specialty certified coder. Accurate coding to the highest level of specificity is essential to clinicians receiving proper credit in MIPS.
- Contact your professional association about their clinical data registry options.
- Determine which improvement activities the practice may already be doing. Consider implementing other activities to boost the practice's MIPS final score.
- Review performance feedback reports to identify your provider's most costly patient population conditions and diagnoses. Identify targeted care delivery plans for these conditions. Feedback reports are available to authorized users on www.qpp.cms.gov.

# MIPS Reporting Requirements At-A-Glance

| COST 20% | QUALITY 40% | IMPROVEMENT ACTIVITIES* 15% | PROMOTING INTEROPERABILITY 25% |
|---|---|---|---|
| No reporting requirement; data pulled from administrative claims.<br><br>To be scored:<br>• Case minimum of 20 for Total Per Capita Cost measure<br>• Case minimum of 35 for MSPB<br>• Case minimum of 10 for procedural episodes<br>• Case minimum of 20 for acute inpatient medical condition episodes | Report a full year of data on 6 measures, including 1 outcome or high priority measure, or all measures in a specialty measure set | Groups of 16+ clinicians: Report on a minimum of 4 medium weighted activities or 2 high-weighted activities for at least a continuous 90-day period<br><br>Small practices (15 or fewer clinicians): Report 1 high-weighted or 2 medium-weighted activities for at least a continuous 90-day period | 1. Must use 2015 Edition Certified EHR Technology for more than 90 consecutive days in the performance period<br>2. Submit a "Yes" to the Prevention of Information Blocking Attestation<br>3. Submit a "Yes" to the ONC Direct Review Attestation<br>4. Submit a "Yes" to the Security Risk Analysis measure<br>5. Report the required measures under each objective or claim the exclusions, if applicable |

*Full credit is given for IA to MIPS APMs and PCMH.

Appendix 2

# Quality Measures Classified as "High Priority"

Below is a list of quality measures that are classified as high priority. Refer to measure specifica-tions (in the Resource Library on qpp.cms.gov) for details on all measures, such as collection types that may be used to report each measure.

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| Allergy/ Immunology | 130 | Documentation of Current Medications in the Medical Record |
| | 238 | Use of High-Risk Medica-tions in Older Adults |
| | 331 | Adult Sinusitis: Antibiotic Prescribes for Acute Viral Sinusitis (Overuse) |
| | 332 | Adult Sinusitis: Appro-priate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) |
| | 338 | HIV Viral Load Suppression |
| | 340 | HIV Medical Visit Frequency |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 398 | Optimal Asthma Control |
| | 444 | Medication Management for People with Asthma |
| Anesthesiology | 76 | Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections: |
| | 404 | Anesthesiology Smoking Abstinence |
| | 424 | Perioperative Temperature Management |
| | 430 | Prevention of Post-Opera-tive Nausea and Vomiting (PONV) – Combination Therapy: |
| | 463 | Prevention of Post-Operative Vomiting (POV) |
| | | – Combination Therapy (Pediatrics) |
| | 477 | Multimodal Pain Management |
| Audiology | 130 | Documentation of Current Medications in the Medical Record |
| | 154 | Falls: Risk Assessment |
| | 155 | Falls: Plan of Care |
| | 181 | Elder Maltreatment Screen and Follow-Up Plan |
| | 182 | Functional Outcome Assessment |
| | 261 | Referral for Otologic Evalu-ation for Patients with Acute or Chronic Dizziness |
| | 318 | Falls: Screening for Future Fall Risk |
| Cardiology | 47 | Advance Care Plan |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 236 | Controlling High Blood Pressure |
| | 238 | Use of High-Risk Medica-tions in Older Adults |
| | 243 | Cardiac Rehabilitation Patient Referral from an Outpatient Setting |
| | 322 | Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Eval-uation in Low-Risk Surgery Patients |
| | 323 | Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI) |
| | 324 | Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymp-tomatic, Low-Risk Patients |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| | 344 | Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2) |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 441 | Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control) |
| Chiropractic Medicine | 182 | Functional Outcome Assessment |
| | 217 | Functional Status Change for Patients with Knee Impairments |
| | 218 | Functional Status Change for Patients with Hip Impairments |
| | 219 | Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments |
| | 220 | Functional Status Change for Patients with Low Back Impairments |
| | 221 | Functional Status Change for Patients with Shoulder Impairments |
| | 222 | Functional Status Change for Patients with Elbow, Wrist or Hand Impairments |
| | 478 | Functional Status Change for Patients with Neck Impairments |
| Clinical Social Work | 47 | Advance Care Plan |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 181 | Elder Maltreatment Screen and Follow-Up Plan |
| | 286 | Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia |
| | 288 | Dementia: Education and Support of Caregivers for Patients with Dementia |
| | 370 | Depression Remission at Twelve Months |
| | 382 | Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment |
| | 383 | Adherence to Antipsychotic Medications for Individuals with Schizophrenia |
| Dentistry | 378 | Children Who Have Dental Decay or Cavities |
| Dermatology | 130 | Documentation of Current Medications in the Medical Record |
| | 137 | Melanoma: Continuity of Care – Recall System |
| | 138 | Melanoma: Coordination of Care |
| | 265 | Biopsy Follow-Up |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 410 | Psoriasis: Clinical Response to Systemic Medications |
| | 440 | Basal Cell Carcinoma (BCC)/ Squamous Cell Carcinoma (SCC): Biopsy Reporting Time – Pathologist to Clinician |
| Diagnostic Radiology | 145 | Radiology: Exposure Dose Indices or Exposure Time and Number of Images Reported for Procedures Using Fluoroscopy |
| | 147 | Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy |
| | 225 | Radiology: Reminder System for Screening Mammogram |
| | 360 | Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| | 364 | Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines |
| | 405 | Appropriate Follow-up Imaging for Incidental Abdominal Lesions |
| | 406 | Appropriate Follow-Up Imaging for Incidental Thyroid Nodules in Patients |
| Electrophysiology Cardiac Specialist | 392 | HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation |
| | 393 | Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision |
| Emergency Medicine | 66 | Appropriate Testing for Children with Pharyngitis |
| | 93 | Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use |
| | 116 | Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis |
| | 331 | Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse) |
| | 332 | Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) |
| | 415 | Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older |
| | 416 | Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 through 17 Years |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| Endocrinology | 1 | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 236 | Controlling High Blood Pressure |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| Family Medicine | 1 | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9 %) |
| | 24 | Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older |
| | 47 | Advance Care Plan |
| | 50 | Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older |
| | 65 | Appropriate Treatment for Children with Upper Respiratory Infection (URI) |
| | 66 | Appropriate Testing for Pharyngitis |
| | 93 | Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use |
| | 116 | Avoidance of Antibiotic Treatment for Acute Bronchitis/Brochiolitis |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 154 | Falls: Risk Assessment |
| | 155 | Falls: Plan of Care |
| | 181 | Elder Maltreatment Screen and Follow-Up Plan |
| | 182 | Functional Outcome Assessment |
| | 236 | Controlling High Blood Pressure |
| | 238 | Use of High-Risk Medications in Older Adults |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| | 243 | Cardiac Rehabilitation Patient Referral from an Outpatient Setting |
| | 305 | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment |
| | 318 | Falls: Screening for Future Fall Risk |
| | 321 | CAHPS for MIPS Clinician/ Group Survey |
| | 331 | Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse) |
| | 332 | Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) |
| | 338 | HIV Viral Load Suppression |
| | 342 | Pain Brought Under Control Within 48 Hours |
| | 370 | Depression Remission at Twelve Months |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 377 | Functional Status Assessments for Congestive Heart Failure |
| | 383 | Adherence to Antipsychotic Medications for Individuals with Schizophrenia |
| | 398 | Optimal Asthma Control |
| | 441 | Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control) |
| | 443 | Non-Recommended Cervical Cancer Screening in Adolescent Females |
| | 444 | Medication Management for People with Asthma |
| | 464 | Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use |
| | 468 | Continuity of Pharmacotherapy for Opioid Use Disorder (OUD) |
| | 472 | Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture |
| Gastroenterology | 47 | Advance Care Plan |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 185 | Colonoscopy Interval for Patients with a History of Adenomatous Polyps -- Avoidance of Inappropriate Use |
| | 320 | Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 439 | Age Appropriate Screening Colonoscopy |
| General Surgery | 21 | Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin |
| | 23 | Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) |
| | 47 | Advance Care Plan |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 354 | Anastomotic Leak Intervention: |
| | 355 | Unplanned Reoperation within the 30 Day Postoperative Period: |
| | 356 | Unplanned Hospital Readmission within 30 Days of Principal Procedure |
| | 357 | Surgical Site Infection (SSI) |
| | 358 | Patient-Centered Surgical Risk Assessment and Communication |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| Geriatrics | 47 | Advance Care Plan |
| | 50 | Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 154 | Falls: Risk Assessment |
| | 155 | Falls: Plan of Care |
| | 181 | Elder Maltreatment Screen and Follow-Up Plan |
| | 238 | Use of High-Risk Medications in the Elderly |
| | 286 | Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia |
| | 288 | Dementia Education and Support of Caregivers for Patients with Dementia |
| | 370 | Depression Remission at Twelve Months |
| | 455 | Percentage of Patients who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better) |
| | 476 | Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia |
| Hospitalists | 47 | Advance Care Plan |
| | 76 | Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections |
| | 130 | Documentation of Current Medications in the Medical Record |
| Infectious Disease | 130 | Documentation of Current Medications in the Medical Record |
| | 338 | HIV Viral Load Suppression |
| | 340 | HIV Medical Visit Frequency |
| Internal Medicine | 1 | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) |
| | 24 | Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older |
| | 47 | Advance Care Plan |
| | 50 | Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older |
| | 93 | Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use |
| | 116 | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 154 | Falls: Risk Assessment |
| | 155 | Falls: Plan of Care |
| | 181 | Elder Maltreatment Screen and Follow-Up |
| | 236 | Controlling High Blood Pressure |
| | 238 | Use of High-Risk Medications in Older Adults |
| | 243 | Cardiac Rehabilitation Patient Referral from an Outpatient Setting |
| | 305 | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment |
| | 318 | Falls: Screening for Future Fall Risk |
| | 321 | CAHPS for MIPS Clinician/ Group Survey: |
| | 331 | Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse |
| | 332 | Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| | 338 | HIV Viral Load Suppression |
| | 342 | Pain Brought Under Control Within 48 Hours |
| | 370 | Depression Remission at Twelve Months |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report: |
| | 377 | Functional Status Assessments for Congestive Heart Failure |
| | 383 | Adherence to Antipsychotic Medications for Individuals with Schizophrenia |
| | 391 | Follow-Up After Hospitalization for Mental Illness (FUH) |
| | 398 | Optimal Asthma Control |
| | 441 | Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control) |
| | 443 | Non-Recommended Cervical Cancer Screening in Adolescent Females |
| | 444 | Medication Management for People with Asthma |
| | 468 | Continuity of Pharmacotherapy for Opioid Use Disorder (OUD) |
| | 472 | Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture |
| Intervential Radiology | 76 | Prevention of Central Venous: Catheter (CVC) - Related Bloodstream Infections |
| | 145 | Radiology: Exposure Dose Indices or Exposure Time and Number of Images Reported for Procedures Using Fluoroscopy |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 409 | Clinical Outcome Post Endovascular Stroke Treatement |
| | 413 | Door to Puncture Time for Endovascular Stroke Treatment |
| | 420 | Varicose Vein Treatment with Saphenous Ablation: Outcome Survey |
| | 465 | Uterine Artery Embolization Technique: Documenation of Angiographic Endpoints and Interrogation of Ovarian Arteries |
| Mental/ Behavioral Health | 130 | Documentation of Current Medications in the Medical Record |
| | 181 | Elder Maltreatment Screen and Follow-Up Plan |
| | 286 | Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia |
| | 288 | Demential Education and Support of Caregivers for Patients with Dementia |
| | 370 | Depression Remission at Twelve Months |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 382 | Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment |
| | 383 | Adherence to Antipsychotic Medications for Individuals with Schizophrenia |
| | 391 | Follow-up After Hospitalization for Mental Illness (FUH) |
| | 468 | Continuity of Pharmacotherapy for Opioid Use Disorder (OUD) |
| Nephrology | 1 | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) |
| | 47 | Advance Care Plan: |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 182 | Functional Outcome Assessment |
| | 318 | Falls: Screening for Future Fall Risk |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| Neurology | 47 | Advance Care Plan |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 154 | Falls: Risk Assessment |
| | 155 | Falls: Plan of Care |
| | 181 | Elder Maltreatment Screen and Follow-Up Plan |
| | 286 | Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia |
| | 288 | Dementia: Education and Support of Caregivers for Patients with Dementia |
| | 293 | Parkinson's Disease: Rehabilitative Therapy Options |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 386 | Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences |
| | 419 | Overuse of Imaging for the Evaluation of Primary Headache |
| Neurosurgical | 21 | Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin |
| | 23 | Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 260 | Rate of Carotid Endarterctomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2) |
| | 344 | Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Disharged to Home by Post-Operative Day #2) |
| | 409 | Clinical Outcome Post Endovascular Stroke Treatment |
| | 413 | Door to Puncture Time for Endovascular Stroke Treatment |
| | 459 | Average Change in Back Pain Following Lumbar Discectomy/Laminotomy |
| | 460 | Average Change in Back Pain Following Lumbar Fusion |
| | 461 | Average Change in Leg Pain Following Lumbar Discectomy and/or Laminotomy |
| | 469 | Average Change in Functional Status Following Lumbar Fusion Surgery |
| | 471 | Average Change in Functional Status Following Lumbar Discectomy/Laminotomy Surgery |
| | 473 | Average Change in Leg Pain Following Lumbar Fusion Surgery |
| Nutrition/ Dietician | 1 | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 181 | Elder Maltreatment Screen and Follow-Up Plan |
| Obstetrics/ Gynecology | 47 | Advance Care Plan |
| | 50 | Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 236 | Controlling High Blood Pressure |
| | 265 | Biopsy Follow-Up |
| | 335 | Maternity Care: Elective Delivery or Early Induction Without Medical Indication at ≥ 37 and < 39 Weeks (Overuse) |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| | 336 | Maternity Care: Post-partum Follow-up and Care Coordination |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 422 | Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury |
| | 429 | Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy |
| | 432 | Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair |
| | 433 | Proportion of Patients Sustaining a Bowel Injury at the Time of any Pelvic Organ Prolapse Repair |
| | 434 | Proportion of Patients Sustaining A Ureter Injury at the Time of Pelvic Organ Prolapse Repair |
| | 443 | Non-Recommended Cervical Cancer Screening in Adolescent Females |
| | 448 | Appropriate Workup Prior to Endometrial Ablation |
| | 472 | Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture |
| Oncology/ Hematology | 47 | Advance Care Plan |
| | 102 | Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 143 | Oncology: Medical and Radiation – Pain Intensity Quantified |
| | 144 | Oncology: Medical and Radiation – Plan of Care for Moderate to Severe Pain: |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 450 | Trastuzumab Received By Patients With AJCC Stage I (T1c) – III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy |
| | 452 | Patients with Metastatic Colorectal Cancer and RAS (KRAS or NRAS) Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies |
| | 453 | Percentage of Patients who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score – better) |
| | 455 | Percentage of Patients who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better) |
| | 457 | Percentage of Patients who Died from Cancer Admitted to Hospice for Less than 3 Days (lower score – better) |
| Ophthalmology | 19 | Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 141 | Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care |
| | 191 | Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery |
| | 238 | Use of High-Risk Medication in Older Adults |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| | 303 | Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery |
| | 304 | Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery: |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report: |
| | 384 | Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery |
| | 385 | Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery |
| | 389 | Cataract Surgery: Difference Between Planned and Final Refraction |
| Orthopedic Surgery | 21 | Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin |
| | 23 | Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) |
| | 24 | Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older |
| | 47 | Advance Care Plan |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 154 | Falls: Risk Assessment |
| | 155 | Falls: Plan of Care |
| | 182 | Functional Outcome Assessment |
| | 217 | Functional Status Change for Patients with Knee Impairments |
| | 218 | Functional Status Change for Patients with Hip Impairments |
| | 219 | Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments |
| | 220 | Functional Status Change for Patients with Low Back Impairments |
| | 221 | Functional Status Change for Patients with Shoulder Impairments |
| | 222 | Functional Status Change for Patients with Elbow, Wrist or Hand Impairments |
| | 318 | Falls: Screening for Future Fall Risk |
| | 350 | Total Knee Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy |
| | 351 | Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation: |
| | 358 | Patient-Centered Surgical Risk Assessment and Communication |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 375 | Functional Status Assessment for Total Knee Replacement |
| | 376 | Functional Status Assessment for Total Hip Replacement |
| | 459 | Average Change in Back Pain Following Lumbar Discectomy/Laminotomy |
| | 460 | Average Change in Back Pain Following Lumbar Fusion |
| | 461 | Average Change in Leg Pain Following Lumbar Discectomy and/or Laminotomy |
| | 469 | Average Change in Functional Status Following Lumbar Fusion Surgery |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| | 470 | Average Change in Functional Status Following Total Knee Replacement Surgery |
| | 471 | Average Change in Functional Status Following Lumbar Discectomy/Laminotomy Surgery |
| | 473 | Average Change in Leg Pain Following Lumbar Fusion Surgery |
| | 478 | Functional Status Change for Patients with Neck Impairments |
| Otolaryngology | 21 | Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin |
| | 23 | Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) |
| | 47 | Advance Care Plan |
| | 65 | Appropriate Treatment for Upper Respiratory Infection (URI) |
| | 93 | Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 154 | Falls: Risk Assessment |
| | 155 | Falls: Plan of Care |
| | 265 | Biopsy Follow-Up |
| | 318 | Falls: Screening for Future Fall Risk |
| | 331 | Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse) |
| | 332 | Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) |
| | 357 | Surgical Site Infection (SSI) |
| | 358 | Patient-Centered Surgical Risk Assessment and Communication |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 398 | Optimal Asthma Control |
| | 464 | Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use |
| Pathology | 395 | Lung Cancer Reporting (Biopsy/Cytology Specimens) |
| | 396 | Lung Cancer Reporting (Resection Specimens) |
| | 397 | Melanoma Reporting |
| | 440 | Basal Cell Carcinoma (BCC)/ Squamous Cell Carcinoma (SCC): Biopsy Reporting Time – Pathologist to Clinician |
| Pediatrics | 65 | Appropriate Treatment for Children with Upper Respiratory Infection (URI) |
| | 66 | Appropriate Testing for Children with Pharyngitis |
| | 93 | Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use |
| | 116 | Maternity Care: Elective Delivery or Early Induction Without Medical Indication at < 39 Weeks (Overuse) |
| | 305 | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: |
| | 382 | Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment |
| | 391 | Follow-up After Hospitalization for Mental Illness (FUH) |
| | 398 | Optimal Asthma Control |
| | 444 | Medication Management for People with Asthma |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| | 464 | Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use |
| | 370 | Depression Remission at Twelve Months: |
| Physical Medicine | 47 | Oncology: Medical and Radiation – Pain Intensity Quantified |
| | 130 | Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies |
| | 154 | Optimal Asthma Control |
| | 155 | One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk |
| | 182 | Functional Outcome Assessment |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 468 | Continuity of Pharmacotherapy for Opioid Use Disorder (OUD) |
| Physical Therapy/ Occupational Therapy | 130 | Documentation of Current Medications in the Medical Record |
| | 154 | Falls: Risk Assessment |
| | 155 | Falls: Plan of Care |
| | 181 | Elder Maltreatment Screen and Follow-Up Plan |
| | 182 | Functional Outcome Assessment |
| | 217 | Functional Status Change for Patients with Knee Impairments |
| | 218 | Functional Status Change for Patients with Hip Impairments |
| | 219 | Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments: |
| | 220 | Functional Status Change for Patients with Low Back Impairments |
| | 221 | Functional Status Change for Patients with Shoulder Impairments |
| | 222 | Functional Status Change for Patients with Elbow, Wrist or Hand Impairments |
| | 286 | Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia |
| | 288 | Dementia: Education and Support of Caregivers for Patients with Dementia |
| | 318 | Falls: Screening for Future Fall Risk |
| | 478 | Functional Status Change for Patients with Neck Impairments |
| Plastic Surgery | 21 | Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin |
| | 23 | Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 355 | Unplanned Reoperation within the 30 Day Postoperative Period |
| | 356 | Unplanned Hospital Readmission within 30 Days of Principal Procedure |
| | 357 | Surgical Site Infection (SSI |
| | 358 | Patient-Centered Surgical Risk Assessment and Communication |
| Podiatry | 154 | Falls: Risk Assessment |
| | 155 | Falls: Plan of Care |
| | 318 | Falls: Screening for Future Fall Risk |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| Preventive Medicine | 1 | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%): |
| | 24 | Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older |
| | 47 | Advance Care Plan |
| | 58 | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis |
| | 116 | Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 154 | Falls: Risk Assessment |
| | 155 | Falls: Plan of Care |
| | 182 | Functional Outcome Assessment |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| Pulmonology | 47 | Advance Care Plan |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 236 | Controlling High Blood Pressure |
| | 238 | Use of High-Risk Medications in the Elderly |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 398 | Optimal Asthma Control |
| | 444 | Medication Management for People with Asthma |
| Radiation Oncology | 102 | Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients |
| | 143 | Oncology: Medical and R |
| | 144 | Oncology: Medical and Radiation – Plan of Care for Moderate to Severe Pain |
| Rheumatology | 24 | Communication with the Physician or Other |
| | 47 | Advance Care Plan |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 236 | Controlling High Blood Pressure |
| | 238 | Use of High-Risk Medications in the Elderly |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| Skilled Nursing Facility | 47 | Advance Care Plan |
| | 154 | Falls: Risk Assessment |
| | 155 | Falls: Plan of Care |
| | 181 | Elder Maltreatment Screen and Follow-Up Plan |
| | 238 | Use of High-Risk Medications in Older Adults |
| Speech Language Pathology | 130 | Documentation of Current Medications in the Medical Record |
| | 181 | Elder Maltreatment Screen and Follow-Up Plan |
| | 182 | Functional Outcome Assessment |
| Thoracic Surgery | 21 | Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin |
| | 23 | Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) |
| | 47 | Advance Care Plan |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 164 | Coronary Artery Bypass Graft (CABG): Prolonged Intubation |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| | 167 | Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure |
| | 168 | Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration |
| | 358 | Patient-Centered Surgical Risk Assessment and Communication |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 445 | Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft (CABG) |
| Urgent Care | 65 | Appropriate Treatment for Children with Upper Respiratory Infection (URI) |
| | 66 | Appropriate Testing for Children with Pharyngitis: |
| | 93 | Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use |
| | 116 | Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 331 | Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse) |
| | 332 | Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) |
| | 464 | Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use |
| Urology | 23 | Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients): |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| | 47 | Advance Care Plan |
| | 50 | Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older |
| | 102 | Prostate Cancer: Avoidance of Overuse of Bone Scan for staging Low Risk Prostate Cancer Patients |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 265 | Biopsy Follow-Up |
| | 358 | Patient-Centered Surgical Risk Assessment and Communication |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| | 429 | Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy |
| | 432 | Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair |
| | 433 | Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair |
| | 434 | Proportion of Patients Sustaining a Ureter Injury at the Time of Pelvic Organ Prolapse Repair |
| | 476 | Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia |
| | 478 | International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) change 6-12 months after diagnosis of Benign Prostatic Hyperplasia: |

| Specialty | Quality ID | Measure Title (high priority) |
|---|---|---|
| Vascular Surgery | 21 | Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin |
| | 23 | Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients): |
| | 47 | Advance Care Plan |
| | 130 | Documentation of Current Medications in the Medical Record |
| | 236 | Controlling High Blood Pressure |
| | 258 | Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7) |
| | 259 | Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post Operative Day #2) |
| | 260 | Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2) |
| | 344 | Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2) |
| | 357 | Surgical Site Infection (SSI) |
| | 358 | Patient-Centered Surgical Risk Assessment and Communication |
| | 374 | Closing the Referral Loop: Receipt of Specialist Report: |
| | 420 | Varicose Vein Treatment with Saphenous Ablation: Outcome Survey |
| | 441 | Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control |

For a complete list of new and removed measures, see Appendix 1: Finalized MIPS Quality Measures in the 2021 MPFS and QPP final rule at: https://qpp.cms.gov/about/resource-library

Appendix 3

# High and Medium Weighted Improvement Activities

For the CY 2021 performance period, CMS added two new improvement activities; modified seven existing improvement activities; and deleted 15 improvement activities.

## High-weighted Activities

### Achieving Health Equity

- ✓ Engagement of new Medicaid patients and follow-up
- ✓ Promote Use of Patient-Reported Outcome Tools
- ✓ Provide Education Opportunities for New Clinicians

### Behavioral and Mental Health

- ✓ Implementation of co-location PCP and MH services
- ✓ Implementation of integrated PCBH model
- ✓ Unhealthy alcohol use for patients with occurring conditions of mental health and substance abuse and ambulatory care patients

### Beneficiary Engagement

- ✓ Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
- ✓ Engage Patients and Families to Guide Improvement in the System of Care
- ✓ Drug Cost Transparency

### Care Coordination

- ✓ Patient Navigator Program
- ✓ Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes

### Emergency Response & Preparedness

- ✓ Participation in a 60-day or greater effort to support domestic or international humanitarian needs.
- ✓ COVID-19 Clinical Data Reporting with or without Clinical Trial

### Expanded Practice Access

- ✓ Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record

### Patient Safety & Practice Assessment

- ✓ CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain
- ✓ Completion of CDC Training on Antibiotic Stewardship
- ✓ Consultation of the Prescription Drug Monitoring program
- ✓ Consulting AUC Using Clinical Decision Support when Ordering Advanced
- ✓ Participation in CAHPS or other supplemental questionnaire
- ✓ PCI Bleeding Campaign
- ✓ Patient medication risk education
- ✓ Use of CDC guideline for clinical decision support to prescribe opioids for chronic pain via clinical decision support

### Population Management

- ✓ Anticoagulant management improvements
- ✓ Glycemic management services
- ✓ RHC, IHS or FQHC quality improvement activities
- ✓ Use of QCDR for feedback reports that incorporate population health

# Medium Weighed Activities

## Achieving Health Equity

- ✓ MIPS Eligible Clinician Leadership in Clinical Trials or CBPR
- ✓ Comprehensive eye exams

## Behavioral and Mental Health

- ✓ Depression screening
- ✓ Diabetes screening
- ✓ Electronic Health Record Enhancements for BH data capture
- ✓ MDD prevention and treatment interventions
- ✓ Tobacco use
- ✓ Completion of collaborative care management training program

## Beneficiary Engagement

- ✓ Engagement of patients through implementation of improvements in patient portal
- ✓ Engagement of Patients, Family, and Caregivers in Developing a Plan of Care
- ✓ Engagement with QIN-QIO to implement self-management training programs
- ✓ Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities
- ✓ Evidenced-based techniques to promote self-management into usual care
- ✓ Implementation of condition-specific chronic disease self-management support programs
- ✓ Improved Practices that Disseminate Appropriate Self-Management Materials
- ✓ Improved Practices that Engage Patients Pre-Visit
- ✓ Integration of patient coaching practices between visits
- ✓ Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.
- ✓ Participation in a QCDR, that promotes use of patient engagement tools.
- ✓ Provide peer-led support for self-management.
- ✓ Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.
- ✓ Use evidence-based decision aids to support shared decision-making.
- ✓ Use group visits for common chronic conditions (e.g., diabetes).
- ✓ Use of certified EHR to capture patient reported outcomes
- ✓ Use of tools to assist patient self-management
- ✓ Financial navigation program

## Care Coordination

- ✓ Care coordination agreements that promote improvements in patient tracking across settings
- ✓ Care transition documentation practice improvements
- ✓ Care transition standard operational improvements
- ✓ Implementation of documentation improvements for practice/process improvements
- ✓ Implementation of improvements that contribute to more timely communication of test results
- ✓ Implementation of practices/processes for developing regular individual care plans
- ✓ Implementation of use of specialist reports back to referring clinician or group to close referral loop
- ✓ Practice improvements for bilateral exchange of patient information
- ✓ Practice improvements that engage community resources to support patient health goals
- ✓ Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients
- ✓ PSH Care Coordination
- ✓ Regular training in care coordination
- ✓ Relationship-centered communication

## Emergency Response & Preparedness

- ✓ Participation on Disaster Medical Assistance Team, registered for 6 months.

## Expanded Practice Access

- ✓ Additional improvements in access as a result of QIN/QIO TA
- ✓ Use of telehealth services that expand practice access
- ✓ Collection and use of patient experience and satisfaction data on access
- ✓ Participation in User Testing of the Quality Payment Program Website
- ✓ Collection and use of patient experience and satisfaction data on access
- ✓ Participation in User Testing of the Quality Payment Program Website (https://qpp.cms.gov/)
- ✓ Use of telehealth services that expand practice access

## Patient Safety & Practice Assessment

- ✓ Administration of the AHRQ Survey of Patient Safety Culture
- ✓ Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event
- ✓ Completion of the AMA STEPS Forward program
- ✓ Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments
- ✓ Cost Display for Laboratory and Radiographic Orders
- ✓ Implementation of an ASP
- ✓ Implementation of analytic capabilities to manage total cost of care for practice population
- ✓ Implementation of fall screening and assessment programs
- ✓ Implementation of formal quality improvement methods, practice changes or other practice improvement processes
- ✓ Invasive Procedure or Surgery Anticoagulation Medication Management
- ✓ Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes
- ✓ Measurement and improvement at the practice and panel level
- ✓ Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or other similar activity.
- ✓ Participation in an AHRQ-listed patient safety organization.
- ✓ Participation in Joint Commission Evaluation Initiative
- ✓ Participation in MOC Part IV
- ✓ Participation in private payer CPIA
- ✓ Use of decision support and standardized treatment protocols
- ✓ Use of patient safety tools
- ✓ Use of QCDR data for ongoing practice assessment and improvements

## Population Management

- ✓ Advance Care Planning
- ✓ Chronic care and preventative care management for paneled patients
- ✓ Engagement of community for health status improvement
- ✓ Glycemic Referring Services
- ✓ Glycemic Screening Services
- ✓ Implementation of episodic care management practice improvements
- ✓ Implementation of medication management practice improvements
- ✓ Implementation of methodologies for improvements in longitudinal care management for high-risk patients
- ✓ Population empanelment
- ✓ Provide Clinical-Community Linkages
- ✓ Regular review practices in place on targeted patient population needs
- ✓ Use of toolsets or other resources to close healthcare disparities across communities

# MACRA Terminology and Common Acronyms

| | |
|---|---|
| ACA (Affordable Care Act) | The Patient Protection and Affordable Care Act of 2010, or Obamacare. |
| ACI | Advancing Care Information (replaced Meaningful Use), and renamed Promoting Interoperability in 2018 |
| ACO | Accountable care organization |
| AF | Adjustment factor |
| APMs (Alternative Payment Models) | One of two payment tracks under MACRA. Examples include ACOs, patient-centered medical homes, bundled payment models, and other initiatives. |
| APP | APM Performance Pathway |
| Advanced APM | Not all APMs are "advanced." An Advanced APM must meet the legislative definition: at least 50 percent of participants must use CEHRT; payments must be based on quality measures comparable to those used in MIPS (of which one must be an outcome measure); and the entity must bear more than nominal financial risk (or is a CMMI Medical Home Model expanded by the secretary of HHS). |
| CAHPS | Consumer Assessment of Healthcare Providers Survey. |
| CEC (Comprehensive ESRD Care Model) | Large Dialysis Organization (LDO) arrangement or non- LDO arrangement. Only the LDO arrangement qualifies as an Advanced APM. The non-LDO does not qualify because it does not bear financial risk. |
| CEHRT (Certified EHR Technology) | Certification of EHR products is done by the Office of the National Coordinator of Health Information Technology (ONC). |
| CHIP | Children's Health Insurance Program |
| CMMI (Center for Medicare & Medicaid Innovation) | This federal agency oversees programs such as MSSP, TCPI, ACOs. |
| CMS | Centers for Medicare & Medicaid Services |
| CPC+ (Comprehensive Primary Care Plus) | CPC+ is a five-year model that began January 2017, replacing CPC Classic. CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through a regionally based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment. |
| CPCI (Comprehensive Primary Care Initiative) Classic | This was replaced by CPC+ in January 2017. CPC Classic is a collaboration between CMS and commercial and state health insurance plans in seven markets to offer population based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five comprehensive primary care functions: (1) Risk stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; (5) Coordination of Care across the Medical Neighborhood. |
| CPIA | Clinical practice improvement activity |
| CPS (Composite Performance Score) | This is the score that represents the total from each performance category of MIPS (Quality + Improvement Activities + Promoting Interoperability + Cost). MIPS final score is the preferred term, and means the same thing. |

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| CQM (clinical quality measure) | Tools that help measure and track the quality of healthcare services that eligible clinicians, eligible hospitals, and critical access hospitals provide. |
| EC (eligible clinician) | A term used to indicate healthcare professionals who qualify to participate in MIPS. |
| eCQM | Healthcare providers are required to report CQMs electronically (eCQMs), which use data from EHRs and/or health information technology systems to measure healthcare quality beginning January 2018. |
| EHR | Electronic health record |
| EIDM | Enterprise Identity Management System |
| EP | Eligible professional |
| FFS (Fee for Service) | Under this payment system, physicians are based on services provided. Traditional Medicare (Part B) is based on FFS payments. |
| IA (Improvement Activities) | Formerly referred to as CPIA, or Clinical Practice Improvement Activities, IAs are one component of the total MIPS composite performance score. |
| Low-volume threshold | The criteria MIPS eligible clinicians must meet to qualify for MIPS payment adjustments. |
| MACRA (Medicare Access and CHIP Reauthorization Act of 2015) | This law reformed the Medicare payment system, replacing the sustainable growth rate and instituting a payment system that is "value-based." The goal is to create a sustainable payment system for physicians. The new payment system began in 2019, based on 2017 data. |
| MIPS (Merit-Based Incentive Payment System) | One of two payment tracks under MACRA. MIPS consolidates the Physician Quality Reporting System, Value-Based Payment Modifier Program, and Medicare Electronic Health Records Incentive Program into a single program. |
| MIPS APM | MIPS APM meet three criteria: APM entities participate in an APM under an agreement with CMS; the APM requires APM entities to include at least one MIPS eligible clinician on the participation list; and the APM based payment incentives on performance. Participants in MIPS APMs are not exempt from MIPS but receive special scoring considerations under the "MIPS APM scoring standard." |
| MIPS Final Score | The MIPS score is the sum of the scores achieved in the Quality, Cost, Promoting Interoperability, and Improvement Activities performance categories. |
| MPFS | Medicare Physician Fee Schedule |
| MSPB | Medicare spending per beneficiary |
| MSSP | Medicare Shared Savings Program |
| MU | Meaningful Use |
| MVP | MIPS Value Pathway |
| NPI | National Provider Identifier |
| OCM (Oncology Care Model) | There are two types of Oncology Care Models: 1-sided risk and 2-sided risk arrangements. Those that are 2-sided risk arrangements qualify as Advanced APMs. |
| PCMH (Patient Centered Medical Home) | In the PCMH model, the physician practice coordinates all of the patient care, even those with chronic conditions. Nationally recognized patient centered medical homes are accredited by: (1) the Accreditation Association for Ambulatory Healthcare, (2) the National Committee for Quality Assurance (NCQA) PCMH Recognition, (3) the Joint Commission Designation, or (4) the Utilization Review Accreditation Commission (URAC). |

| | |
|---|---|
| PECOS | Provider Enrollment, Chain, and Ownership System |
| PFPM (Physician Focused Payment Models) | These are APMs wherein Medicare is a payer, which includes physician group practices or individual physicians as APM entities. |
| PQRS (Physician Quality Reporting System) | A quality reporting program that encourages EPs and group practices to report information on the quality of care to Medicare. This program ended Dec. 31, replaced by MIPS. |
| PTAC (Physician-focused Payment Model Technical Advisory Committee) | The body that reviews and provides comments and recommendations on PFPMs submitted by stakeholders. The secretary must establish, through notice and comme nt rulemaking, criteria for PFPMs, including models for specialist physicians that could be used by the PTAC for making its comments and recommendations. |
| Quality Data Codes (QDCs) | QDCs are specified CPT® II codes and G codes used for submission of quality data for MIPS. You'll also need to apply encounter codes, including ICD-10-CM, CPT® Category I, or HCPCS Level II codes to show which patients should be added toward the denominator/numerator of the quality measure. |
| QCDR (Qualified clinical data registry) | An entity approved by the Centers for Medicare & Medicaid Services that collects medical and/or clinical data for patient and disease tracking to foster improvement in the quality of care provided to patients. |
| QP (Qualifying APM Participant) | QPs are clinicians who have a certain percentage of Part B payments for professional services or patients furnished Part B professional services through an Advanced APM entity. |
| QPP (Quality Payment Program) | CMS program developed to comply with MACRA. |
| Reporting option | Physicians can report as an individual or as part of a group. A group is defined as two or more eligible clinicians. A physician in a group may choose to participate as an individual under MIPS. |
| SGR (Sustainable Growth Rate) | Former Medicare formula to calculate physician FFS payment rates. Repealed by MACRA. |
| TCPI (Transforming Clinical Practice Initiative) | This is an initiative within CMMI that is designed to help practices implement changes and improvements so that they can participate in APMs. The initiative is designed to support practices over the next four years in sharing, adapting, and further developing their comprehensive quality improvement strategies. |
| TIN (Tax Identification Number) | A number that identifies the billing entity. TINs are used to connect each EC to the entity under which they bill for purposes of calculating MIPS scores or APM participation. |
| VM or VBM (Value-based payment modifier) | This program provided differential payment to a physician or group under the MPFS based on the quality of care furnished compared to the cost of care during a performance period. The VM ended in 2018 and components of the program are used in the MIPS Cost performance category. |