Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM:

Participating in the Quality Performance Category in the 2020 Performance Year

Updated: 06/21/21

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

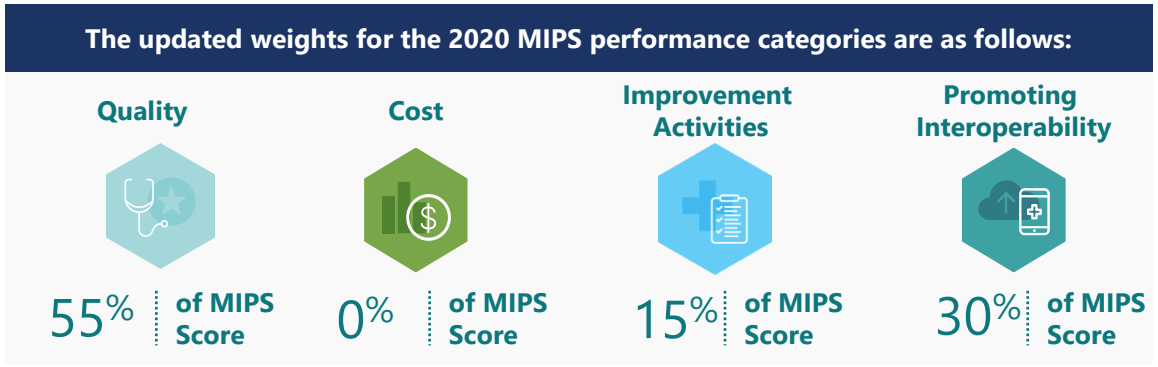
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Reweighting the Cost Performance Category to 0% for the 2020 Performance Period

UPDATED 5/20/2021

CMS is reweighting the Cost performance category from 15% to 0% for the 2020 performance period for all MIPS eligible clinicians regardless of participation as an individual, group, virtual group or APM Entity. The 15% Cost performance category weight will be redistributed to other performance categories in accordance with § 414.1380(c)(2)(ii)(D).

As a reminder, under § 414.1380(c), if a MIPS eligible clinician is scored on fewer than 2 performance categories (meaning 1 performance category is weighted at 100% or all performance categories are weighted at 0%), they will receive a final score equal to the performance threshold and a neutral MIPS payment adjustment for the 2022 MIPS payment year. This reweighting of the Cost performance category applies in addition to the extreme and uncontrollable circumstances (EUC) policy under § 414.1380(c)(2)(i)(A)(6), § 414.1380(c)(2)(i)(A)(8), § 414.1380(c)(2)(i)(C)(2), and § 414.1380(c)(2)(i)(C)(3). Clinicians who aren't covered by the automatic EUC policy or who didn't apply to request reweighting under the EUC will still have their Cost performance category weighted to 0%.



For more information about this policy and a table that includes reweighting scenarios, please refer to the QPP listserv, distributed on 5/20/2021.

Contents

Already know what MIPS is?
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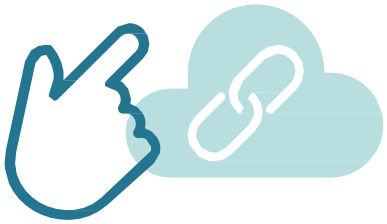
Purpose: *This resource focuses on the Quality performance category, providing the high-level requirements and practical information about quality measure selection, data collection, and submission for the 2020 performance period for individual, group, and virtual group reporting. This resource does not address Alternate Payment Model (APM) participants scored under the APM Scoring Standard. For additional information on the APM Scoring Standard, please review the 2020 APM Scoring Standard User Guide, which will be available in the QPP Resource Library in fall 2020.*

How to Use This Guide

How to Use This Guide



Please Note: This guide was prepared for informational purposes only and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Table of Contents

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Hyperlinks

Hyperlinks to the QPP website are included throughout the guide to direct the reader to more information and resources.

Overview

COVID-19 and 2020 Participation

CMS continues to offer flexibilities to provide relief to clinicians responding to the 2019 Coronavirus (COVID-19) pandemic. We are applying the MIPS automatic extreme and uncontrollable circumstances (EUC) policy to all individual MIPS eligible clinicians for the 2020 performance period. We also reopened the MIPS EUC application for groups, virtual groups, and Alternative Payment Model (APM) Entities through March 31, 2021 at 8 p.m. ET.

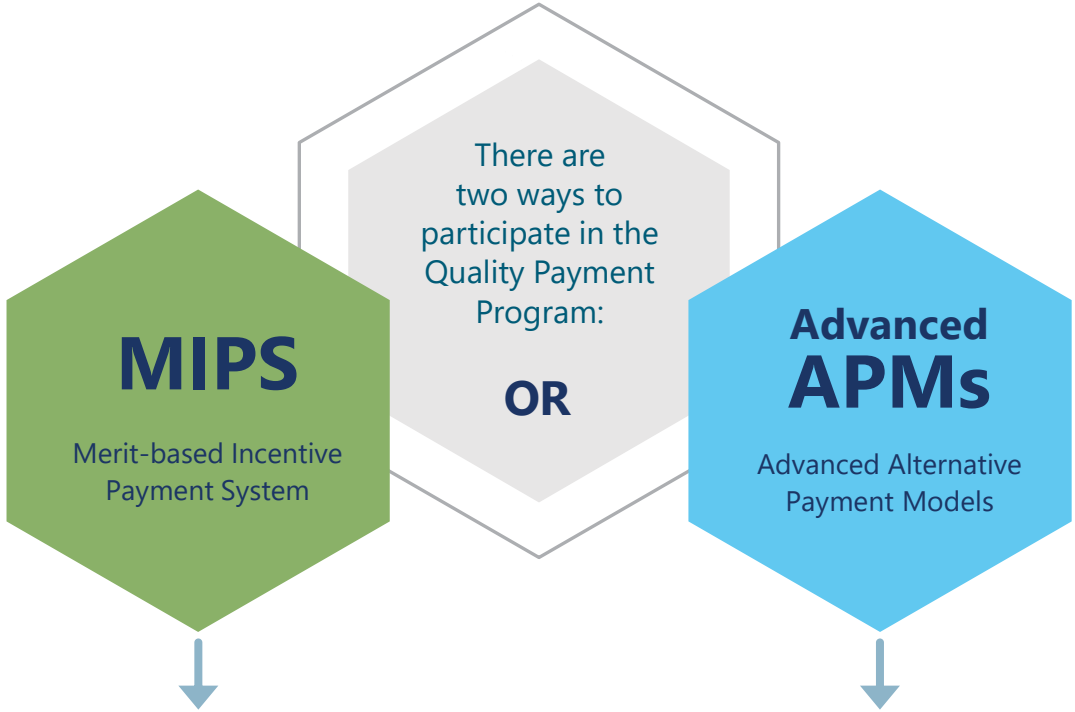
Please note that applications received by March 31, 2021 won't override previously submitted data for individuals, groups and virtual groups. However, data submission for an APM Entity won't override performance category reweighting from an approved application.

For more information about the impact of COVID-19 on Quality Payment Program participation, see the Quality Payment Program COVID-19 Response webpage or the Quality Payment Program COVID-19 Response Fact Sheet.

Overview

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which rewards value in one of two ways:



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

If you participate in an Advanced APM and achieve QP status, you will be excluded from MIPS and may be eligible for a 5% incentive payment

Overview

MIPS Overview

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP), a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program changes how we reimburse MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Under MIPS, we evaluate your performance across 4 performance categories that lead to improved quality and value in our healthcare system.

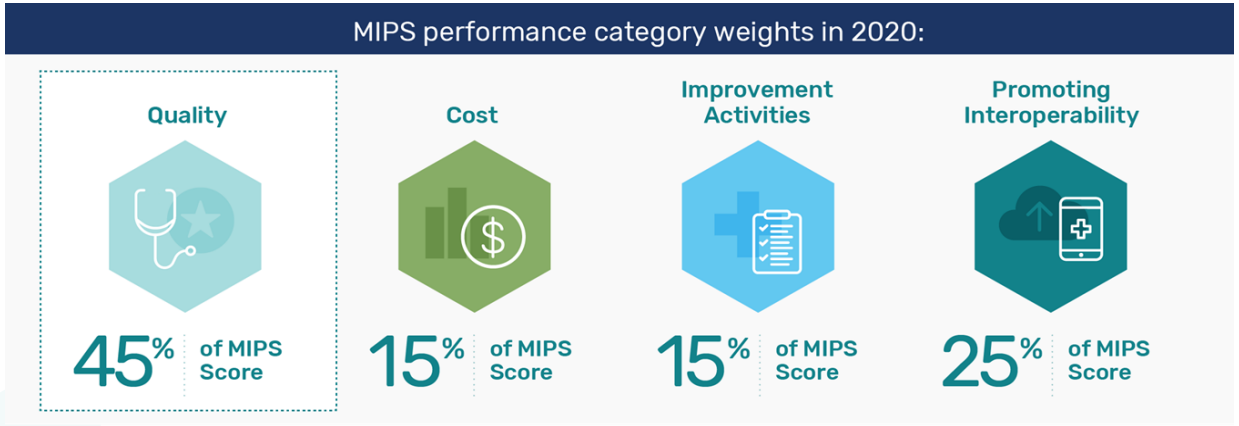
If you're eligible for MIPS in 2020:

- You generally have to submit data for the Quality, Improvement Activities, and Promoting Interoperability performance categories. (We collect and calculate data for the Cost performance category for you.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points. The MIPS performance category weights in the performance year (PY) 2020 are the same as in PY 2019.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based off your performance during the 2020 performance year and applied to payments for covered professional services beginning on January 1, 2022.

Overview

MIPS Overview *(continued)*

This guide includes high-level information about the Quality performance category requirements for individual clinicians, groups and virtual groups.



Please review the 2020 APM Quality Scoring Resources for comprehensive information on the APM Scoring Standard for the Quality performance category, including regulatory guidance and updated procedures for performance year 2020.

For more information on participating in an APM, visit our APMs Overview webpage and check out our APM-related resources in the QPP Resource Library.

To learn more about how to participate in MIPS:

- *Visit the How MIPS Eligibility is Determined and Individual or Group Participation webpages on the Quality Payment Program website.*
- *View the 2020 MIPS Eligibility and Participation Quick Start Guide.*
- *Check your current MIPS participation status using the QPP Participation Status Tool.*

REMINDER: We are reweighting the Cost performance category to 0% for all MIPS eligible clinicians regardless of participation as an individual, group, virtual group or APM Entity. When no additional reweighting applies, the 2020 MIPS performance category weights are as follows: Quality: 55%, Cost: 0%, Improvement Activities: 15%, Promoting Interoperability: 30%. We are leaving the content in this guide as-is for historical reference.

Quality Basics

Quality Basics

Why Focus on Quality?

The Quality performance category assesses the quality of care you deliver as evidenced by your performance on quality measures.

Quality measures are tools that help us to:

Measure healthcare processes, outcomes, and patient care experiences

AND

Link outcomes that relate to one or more of the following quality goals for healthcare that's:

- Effective
- Safe
- Patient-centered
- Equitable
- Timely

For the 2020 performance year, the Quality performance category:

45%

Is generally worth 45% of your MIPS final score (50% under the APM Scoring Standard)

AND

Has a 12-month reporting period (January 1 – December 31, 2020)

Quality Measures

For the 2020 performance period, you can choose measures most meaningful to your practice from more than **200 MIPS quality measures**.

You may also:

- Choose MIPS quality measures from a defined specialty measure set developed by specialty societies or boards.
- Select additional Qualified Clinical Data Registry (QCDR) measures (outside of the MIPS quality measure sets) if you're working with a QCDR to collect and submit your quality data.

To review the 2020 quality measures, including the specialty sets, visit the "Explore Measures & Activities" section of the Quality Payment Program website or review the 2020 QCDR measure specifications.[1]

Once you've found the quality measures that work for you, you'll need to look at the appropriate measure specifications for the collection type you choose to utilize.

[1] Please check the Resource Library for updated QCDR measure specifications throughout the year as measure specifications may change.

Quality Basics

Quality Measures *(continued)*

Below is an overview of the 7 categories of quality measures you can report for the Quality performance category:

Quality Measures by Measure Type			
Process Measures	**Outcome Measures**	**Structure Measures**	**Efficiency Measures**
Process measures show what doctors or other clinicians do to maintain or improve the health of healthy patients or those diagnosed with a given condition or disease. These measures usually specify generally accepted recommendations for clinical practice. Example: The percentage of patients getting preventive services (such as mammograms or immunizations).	Outcome measures show how a healthcare service or intervention affects patients' health status. Example: The rate of surgical complications or hospital-acquired infections, such as surgical site infections.	Structure measures give consumers a sense of a healthcare provider's capacity, systems, and processes to provide high-quality care. Example: Utilizing electronic support systems such as a continuity of care recall system or a reminder system for mammogram screenings. Checking for the availability of diagnostics for patient follow up and comparisons.	Efficiency measures can be used to assess the variability of the cost of healthcare and to direct efforts to make healthcare more affordable. Example: Ordering cardiac imaging when it does not meet the appropriate use criteria. Overusing neuroimaging in a target patient population (such as patients with headaches and a normal neurological exam).
Patient Engagement/Experience Measures	**Intermediate Outcome Measures**	**Patient-Reported Outcome Measures**	
Patient engagement/experience measures use direct feedback from patients and their caregivers about the experience of receiving care. The information is usually collected through surveys. Example: Administering the CAHPS for MIPs Clinician/Group Survey.	Intermediate outcome measures assess a factor or short-term result that contributes to an ultimate outcome, such as having an appropriate cholesterol level. Over time, low cholesterol helps protect against heart disease. Under MIPS, intermediate outcome measures meet the outcome measure criteria. Example: Reducing blood pressure in the short-term decreases the risk of longer-term outcomes such as cardiac infarction or stroke.	Patient-reported outcome measures are derived from outcomes reported by patients and can include any report of a patient's health condition, health behavior, or healthcare experience. These reports come directly from the patient without interpretation of the patient's response by a clinician. Under MIPS, patient-reported outcome measures meet the outcome measure criteria. Example: The percentage of patients who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey.	

Quality Basics

Quality Measures *(continued)*

As part of the Meaningful Measures initiative, we continue to incrementally remove process measures that require a limited quality action so we can move towards a streamlined inventory of meaningful and robust quality measures. For this approach, prior to removal, consideration will be given, but not limited to:

- Whether the removal of the process measure impacts the number of measures available for a specific specialty.
- Whether the measure addresses a priority area highlighted in the Measure Development Plan.
- Whether the measure promotes positive outcomes in patients.
- Considerations and evaluation of the measure's performance data.
- Whether the measure is designated as high priority or not.

In addition, we assess the measure's adoption by checking whether the measure meets case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive performance periods. Removing measures with this methodology ensures that the MIPS quality measures within the program are truly meaningful and measurable areas, where quality improvement is sought and that measures that are low reported for 2 consecutive performance periods are removed from MIPS. For a list of measures removed in 2020, check Appendix A.

MIPS scoring policies emphasize and focus on high priority measures that impact beneficiaries. High-priority measures are not an additional measure type, but fall within these measure categories:

- *Outcome (includes intermediate-outcome and patient-reported)*
- *Appropriate Use*
- *Patient Engagement/Experience*
- *Patient Safety*
- *Efficiency Measures*
- *Care Coordination; and*
- *Opioid-related*

Quality Basics

Reporting Requirements

To participate fully in the Quality performance category, you can:

Report **at least 6 quality measures, including at least 1 outcome measure.** If no outcome measures are applicable, you may report another high-priority measure.

OR

Report all **10 required CMS Web Interface measures.** This option is available to groups, virtual groups, and APM Entities with 25 or more clinicians that register in advance (April 1 – June 30, 2020) of the reporting period. Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program or the Next Generation ACO Model are required to report on the 10 CMS Web Interface measures.

You can choose any 6 measures or select your measures from an available specialty measure set (If the specialty measure set has less than 6 measures, you will meet Quality reporting requirements if you report all measures in the specialty set).

All measures must be reported for the 12-month reporting period, January 1 – December 31, 2020.

NEW IN 2020: 7 new specialty sets were established for speech language pathology, audiology, chiropractic medicine, pulmonology, nutrition/dietician, endocrinology, and clinical social work. Clinical social workers are **not** MIPS eligible clinicians at this time but may be added through future rulemaking.

NOTE: If you're a specialty group, you are not limited to reporting a defined specialty set. You may use the "Explore Measures" tool of the Quality Payment Program website to search for measures relevant to your scope of practice.

Telehealth and the Quality Performance Category

COVID-19: As the COVID-19 pandemic has affected the ability to perform patient-facing encounters, the use of telehealth capabilities has expanded. In response to stakeholder feedback, we have provided telehealth guidance on Medicare Part B Claims and MIPS Clinical Quality Measures (CQMs) for 2020 quality reporting.

Only quality measures where the entire denominator can be captured via telehealth are included within the resource list. We encourage MIPS eligible clinicians, groups, virtual groups, and APM Entities to review other aspects of the quality action within the measure specification, including quality actions that cannot be completed by telehealth.

For a list of 2020 quality measures that currently allow for denominator eligibility to be captured via telehealth for the 2020 performance period, review the 2020 Quality Measures List with Telehealth Guidance posted on the QPP Resource library. If you have any questions on the ability to include encounters to report for measures on this list, please contact the QPP Service Center at 1-866-288-8292 or by e-mail at QPP@cms.hhs.gov. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

For telehealth guidance related to electronic clinical quality measures (eCQMs), please review the Telehealth Guidance for eCQMs for Eligible Professional/Eligible Clinician 2020 Quality Reporting document posted on the Electronic Clinical Quality Improvement (eCQI) Resource Center for more information.

For CMS Web Interface users, please review the 2020 CMS Web Interface measure specifications and supporting documents to determine if telehealth encounters are accepted for a specific measure.

Collection Types

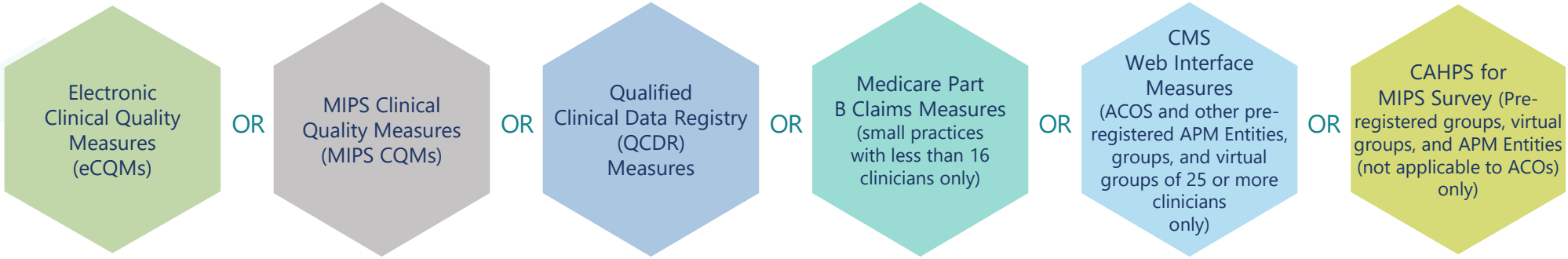
Collection Types

How Can I Collect Quality Data?

Collection Type refers to the way you collect data for a quality measure. An individual quality measure may be collected in multiple ways, and each collection type has its own specification (instructions) for reporting that measure and defining data completeness. For example, Measure 001 has different specifications depending on whether you're reporting the eCQM or as a Medicare Part B claims measure. The data completeness criteria are different as well, since eCQMs include all-payer data, whereas Medicare Part B claims measures are limited to Medicare Part B patients.

UPDATE: For the 2020 performance period, groups and virtual groups with 16 or more eligible clinicians were to be scored on the All-Cause Hospital Readmission measure if they met the case minimum of 200 patients for the measure. However, CMS is suppressing the All-Cause Readmission measure under MIPS for the 2020 performance period. This means the measure will not be scored or attributed to a group or virtual group's quality performance category score. For more information on the 2020 suppressed measures, please refer to the 2020 Suppressed MIPS Quality Measures fact sheet.

There are 6 collection types, or ways you can collect and submit your Quality measure data:



We will aggregate quality measures collected through multiple collection types into a single Quality performance category score. However, CMS Web Interface measures cannot be scored with other collection types other than the CAHPS for MIPS survey and/or administrative claims measures.

If you submit the same measure through multiple collection types, the one with the greatest number of achievement points will be selected for scoring.

Collection Types

How Can I Collect Quality Data? *(continued)*

The table below provides additional details on each collection type, including the types available based on the way you participate and submit data: as an individual, group, virtual group, or APM Entity.

Collection Type	Quality Measures Available for 2020	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type	Scoring Impact
Electronic Clinical Quality Measures (eCQMs)	2020 eCQM specifications	You can report eCQMs if you use technology that meets the 2015 Edition. You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification. If you collect data using multiple EHR systems, you'll need to aggregate your data before it's submitted. eCQMs can be reported in combination with Medicare Part B Claims measures, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure.	• Individuals • Groups • Virtual Groups • APM Entities	1 bonus point will be given for each measure that's collected in 2015 Edition CEHRT and submitted to CMS without manual manipulation (end-to-end electronic reporting) 1 bonus point will be given for each (additional) high priority measure reported 2 bonus points will be given for each additional outcome or patient experience measure reported
MIPS Clinical Quality Measures (MIPS CQMs)	2020 Clinical Quality Measure Specifications and Supporting Documents .	MIPS CQMs are often collected by third-party intermediaries and submitted on behalf of MIPS eligible clinicians. If you chose this collection type, you may work with a Qualified Registry, Qualified Clinical Data Registry, or Health IT vendor to support your data collection and submission. MIPS CQMs can be reported in combination with Medicare Part B Claims measures (small practices only), eCQMs, QCDR measures, and the CAHPS for MIPS Survey.	• Individuals • Groups • Virtual Groups • APM Entities	1 bonus point will be given for each measure (without an eCQM equivalent) that's collected in CEHRT and submitted to CMS without manual manipulation (end-to-end electronic reporting) 1 bonus point will be given for each (additional) high priority measure reported 2 bonus points will be given for each additional outcome measure reported
Qualified Clinical Data Registry (QCDR) Measures	2020 QCDR Measure Specifications	QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures which are approved during their self-nomination period. These measures can be a great option for clinicians and practices that provide specialized care or who have trouble finding MIPS quality measures that are relevant to their practice. You will need to work with a QCDR to report these measures on your behalf. QCDR measures can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B Claims measures (small practices only), and the CAHPS for MIPS Survey.	• Individuals • Groups • Virtual Groups • APM Entities	1 bonus point will be given for each measure collected in CEHRT and submitted to CMS without any manual manipulation (end to end electronic reporting) 1 bonus point will be given for each (additional) high priority measure reported 2 bonus points will be given for each additional outcome measure reported

Collection Types

How Can I Collect Quality Data? *(continued)*

Collection Type	Quality Measures Available for 2020	What Do You Need to Know about This Collection Type?	Who Can Report Using This Collection Type	Scoring Impact
Medicare Part B Claims Measures	2020 Medicare Part B Claims Specifications and Supporting Documents 2020 Part B Claims Reporting Quick Start Guide	Medicare Part B Claims measures are reported with the clinician's individual (rendering) NPI when reporting as a group or virtual group. Medicare Part B Claims measures can be reported in combination with eCQMs, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey.	• Individuals [Small practices (fewer than 16 clinicians) only] • Groups [Small practices (fewer than 16 clinicians) only] • Virtual Groups [Small practices (fewer than 16 clinicians in the virtual group) only] • APM Entities (fewer than 16 clinicians in the Entity)	1 bonus point will be given for each (additional) high priority measure reported 2 bonus points will be given for each additional outcome measure reported
CMS Web Interface	2020 CMS Web Interface Measure Specifications	If you want to report through the CMS Web Interface, groups, virtual groups, and APM Entities need to register between April 1, 2020 and June 30, 2020. (ACOs do not need to register.) Reporting via the Web Interface requires that you submit data on a sample of Medicare patients for each measure within the application.	• Groups (Registered groups with 25 or more clinicians) • Virtual Groups (Registered virtual groups with 25 or more clinicians) • APM Entities (ACOs and Registered APM Entities with 25 or more clinicians)	1 bonus point will be given for each eligible measure (capped at 10% of denominator) collected in your CEHRT and submitted directly to CMS via the CMS Web Interface Application Programming Interface (API) or Excel upload (end-to-end electronic reporting criteria).
CAHPS for MIPS Survey	CAHPS for MIPS Survey Fact Sheet	Groups, virtual groups, and APM Entities could register between April 1, 2020 and June 30, 2020 to administer the CAHPS for MIPS Survey, a survey measuring patient experience and care within a group, virtual group, or APM Entity. This survey must be administered by a CMS-Approved Survey Vendor. This measure can be reported in combination with eCQMs, MIPS CQMs, Medicare Part B Claims measures (small practice only), and QCDR measures.	• Groups (Registered groups with 2 or more clinicians) • Virtual Groups (Registered virtual groups with 2 or more clinicians) • APM Entities (Not available to ACOs) Registered APM Entities with 2 or more clinicians)	This is a patient engagement/experience survey measure that fulfills the requirement to report at least 1 high priority measure if no other outcome measure is available. 2 bonus points may be awarded if you report the required outcome measure through another collection type

ACOs are required to submit data through the CMS Web Interface and to administer the CAHPS for ACO Survey. They also have the option to report measures from other collection types in addition to these required measures. These additional measures would not contribute to the ACO's quality score.

TIP: To review the 2020 quality measures, visit the "Explore Measures & Activities" section of the Quality Payment Program website and be sure to choose the 2020 performance year.

Collection Types

What if I Don't Have 6 Applicable Measures or an Applicable Outcome/High Priority Measure?

We will apply the Eligibility Measure Applicability (EMA) process, which checks if there are additional clinically related quality measures you could have submitted.

Not sure where to begin? Check out the 2020 Quality Quick Start Guide for 5 steps to help you get started with the Quality performance category.

The EMA process is applied when:

You're in a small practice and choose Medicare Part B claims as your collection type

OR

You work with a third-party intermediary to collect and submit MIPS Clinical Quality Measures (CQMs)

AND

You submit fewer than 6 measures (or 6 measures but no outcome/high priority measures) and all your submitted measures are either the Medicare Part B claims or MIPS CQM collection type

If you, your group, virtual group, or APM Entity meet the criteria above, the EMA process:

Determines whether you could have submitted more measures, including outcome and high priority measures

AND

Adjusts scoring if needed to reflect the number of available measures

More information on the 2020 performance period EMA process and the measures we have identified as clinically related will be available on the QPP Resource Library in Fall 2020.

Submitting Quality Data

Submitting Quality Data

Overview

Following the 2020 performance year, we'll assess your performance in the Quality performance category based on the quality measure data you submit.

The data submission period will open **January 4, 2021, and close March 31, 2021.**

Preliminary scoring information will be available beginning **January 4, 2021**, once data has been submitted.

Your final performance feedback will be available **July 2021**.

You can review your performance feedback by signing in to https://qpp.cms.gov/login

Exception: For the Medicare Part B claims submission type, only available to small practices, we receive quality data when claims are submitted for payment. Please note that your Medicare Part B claims measure data must be processed by your Medicare Administrative Contractor (MAC) and received by CMS no later than 60 days following the close of the performance period.

If you transition from one EHR system to another during the performance period, you should aggregate the data from the previous EHR and the new EHR into one report for the full 12 months prior to submitting the data. If a full 12 months of data is unavailable (for example, if aggregation is not possible), your data completeness must reflect the 12-month period. Policy states it is highly suggested that you submit as much data as possible, and you must make efforts to do so especially in the case when multiple EHR products are being utilized under a single TIN. If you are submitting eCQMs, both EHR systems must be 2015 Edition CEHRT.

Submitting Quality Data

What Are My Submission Options?

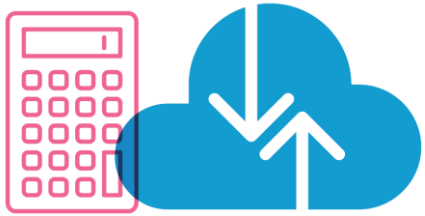
The following chart outlines your options for submitting quality measure data based on your submitter and collection types.

Who is Submitting the Data?	What Types of Measures are Being Submitted? (Collection Type)	How Will the Data be Submitted? (Submission Type)	When is the Data Submitted? (Submission Period)
You (Individual, Group, Virtual Group or APM Entity Representative)	Medicare Part B Claims Measures (small practices only)	Through your routine Medicare Part B billing practices	Throughout the performance period (must be processed by your MAC and received by CMS by March 1, 2021)
	eCQMs	Sign in to qpp.cms.gov and upload a QRDA3 file	January 4 – March 31, 2021
	CMS Web Interface Measures	Manually enter your data and/or upload a file into the CMS Web Interface OR Use our CMS Web Interface API	January 4 – March 31, 2021
Third Party Intermediaries: QCDRs, Qualified Registries, and Health IT Vendors	eCQMs MIPS CQMs QCDR Measures	Sign in to qpp.cms.gov and upload a QRDA3 or QPP JSON file OR Use our QPP Submission API	January 4 – March 31, 2021
CMS Approved Survey Vendors	CAHPS for MIPS Survey	Secure method outside of qpp.cms.gov	Following data collection (standardized annual timeframe)

The level at which you participate in MIPS (individual, group, or virtual group) applies to all performance categories. We will not combine data submitted at the individual, group, and/or virtual group level into a single final score.

For example:

- If you submit any data as an individual, you will be evaluated for all performance categories as an individual.
- If your practice submits any data as a group, you will be evaluated for all performance categories as a group.
- If data is submitted both as an individual and a group, you will be evaluated as an individual and as a group for all performance categories, but your payment adjustment will be based on the higher score.
- If you are scored under the APM Scoring Standard, any data provided at the individual or group level may be rolled up to calculate the APM Entity group score.



Scoring

Scoring

How Will Measures be Scored?

Quality measures submitted for the 2020 performance period will receive between 0 and 10 measure achievement points.

You'll receive:

Between **3** and **10** achievement points

based on your performance in comparison to a benchmark if the quality measure meets the data completeness criteria (**70% for 2020**), has a benchmark, and the volume of cases is sufficient (≥ 20 cases for most measures)

OR

3 achievement points

if your quality measure meets the data completeness criteria but either 1) doesn't have a benchmark and/or 2) the volume of cases you've submitted is insufficient (≤20 cases for most measures)*

OR

0 achievement points

if your quality measure doesn't meet data completeness requirements, which varies by collection type; if you're a small practice with 15 or fewer eligible clinicians, you would receive 3 points*

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

This guide does not cover scoring for MIPS APM participants. Please reference the 2020 APM Scoring Standard User Guide for information on MIPS APM Scoring. The guide will be available on the QPP Resource Library in Spring 2021.

Scoring

Topped Out Quality Measures

A process measure is considered topped out if the median performance rate is 95% or higher (non-inverse measure) or is 5% or lower (inverse measure). A non-process measure is considered topped out if the level of variance is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors. We identify topped out measures annually through our benchmarking process. Measures that are topped out for 4 consecutive years can be proposed for removal through rulemaking.

A measure is considered extremely topped out if the average performance rate is 98% or higher (non-inverse measure) or is 2% or lower (inverse measure). We would consider this measure for removal in the next rulemaking cycle, regardless of whether or not it is in the midst of the topped out measure lifecycle. However, we may consider retaining the measure if there are compelling reasons as to why this measure should not be removed (for example, if the removal would impact the number of measure available to a specialist type).

Are all Topped Out Measures capped at 7 points?

No. A measure is capped at 7 points when it is topped out through the same collection type for 2 consecutive years. The 7-point cap is applied in the second year the measure is identified as topped out.

To identify if a measure is topped out or capped at 7 points, refer to the 2020 Quality Benchmarks.

***A measure may be topped out without being capped at 7 points.** A "Y" (for "Yes") in the **Seven Point Cap** column (Column P) of the benchmark file referenced above indicates the measure is capped at 7 points.*

NOTE: QCDR measures are excluded from the topped out measure lifecycle and special scoring policies. If the QCDR measure is identified as topped out during the annual self-nomination process, it may not be approved for the applicable performance period

Scoring

Benchmarks

Each measure is assessed against its benchmark to determine how many points the measure earns.

How are the Benchmarks Established?

- We establish benchmarks specific to each collection type: QCDR measures, MIPS CQMs, eCQMs, CMS Web Interface measures, the CAHPS for MIPS Survey, Medicare Part B Claims measures, and administrative claims measures.

Whenever possible, we use historical data to establish benchmarks. The 2020 historical benchmarks for eCQMs, MIPS CQMs, Medicare Part B claims measures, and QCDR measures are based on actual performance data that was submitted to the Quality Payment Program for the 2018 performance period. If a quality measure (or specific collection type) doesn't have a historical benchmark, we will attempt to calculate a benchmark based on data submitted for the 2020 performance period.

NEW IN 2020: We established flat benchmarks for Measure 001 (Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)) and Measure 236 (Controlling High Blood Pressure). We will use flat benchmarks to score Measure 236 for all collection types and Measure 001 for the Medicare Part B claims and MIPS Clinical Quality Measure (MIPS CQM) collection types, as historical, performance-based benchmarks may potentially incentivize treatment that may be inappropriate for the patient. For Measure 001, we will use a historical, performance-based benchmark to score the measure for the eCQM collection type.

Some measures may have certain substantive changes to their specifications from one year to the next that the historical data cannot be used to establish a benchmark. For example, Quality ID 217: Functional Status Change for Patients with Knee Impairments was revised to require functional improvement in the 2020 performance period. This substantive change no longer allows direct comparison of performance data from previous submissions. In this case, we will attempt to calculate a benchmark based on data submitted for the 2020 performance period. We use benchmarks from the Medicare Shared Savings Program to assess and score CMS Web Interface measures. The 2020 Medicare Shared Savings Program benchmarks are available here.

UPDATE 3/5/2021: CMS is suppressing the All-Cause Hospital Readmission measure under MIPS for the 2020 performance period. This means the measure will not be scored or attributed a group or virtual group's quality performance category score. For more information on the 2020 suppressed measures, please refer to the 2020 Suppressed MIPS Quality Measures fact sheet.

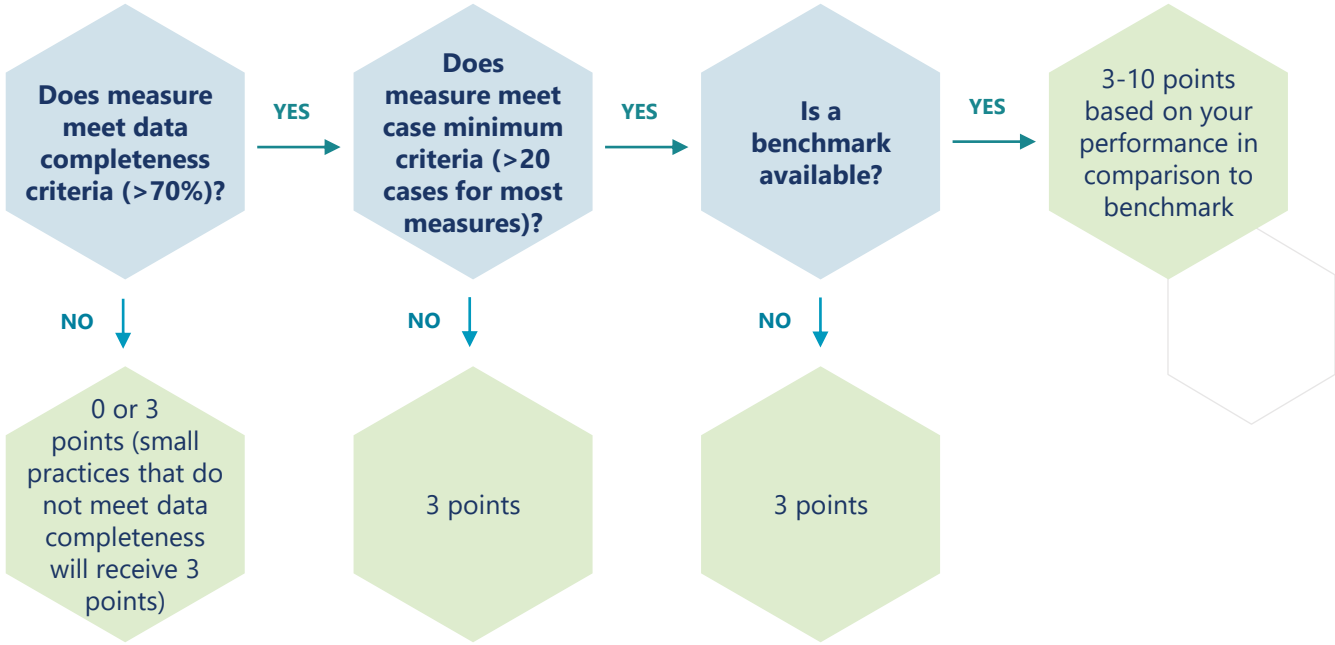
For the CAHPS for MIPS Survey, we will establish a benchmark for each summary survey measure (SSM). Each SSM is awarded 3 to 10 points by comparing performance to the benchmark (similar to other measures). The final CAHPS for MIPS score will be the average number of points across all scored SSMs. For the 2020 CAHPS for MIPS benchmarks, please refer to the 2020 Quality Benchmarks file.

Scoring

Benchmarks *(continued)*

How are benchmarks converted to achievement points?

- Each quality measure with a benchmark is scored using a 10-point scoring system, except for:
  - Measures capped at 7 points because they are in their second consecutive year of being topped out;
  - Measures that don't meet data completeness criteria; and
  - Measures that are submitted with an insufficient case volume.
- Historical performance distribution for each measure is used to define deciles of performance that are used as the benchmark for the measure.



- The decile benchmarks are used to assign a measure score between 3 and 10 points.
- We compare your performance on a quality measure to the performance levels in the national deciles.
- The points you earn are based on the decile range that matches your performance rate.
- For measures with inverse performance rates, such as Measure 001 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (< 9%) where a lower performance rate indicates better performance, decile 10 starts with the lowest performance rate and decile 1 has the highest performance rate.

Scoring

Benchmarks *(continued)*

How are benchmarks converted to achievement points? *(continued)*

NOTE: There is a 3-point floor for measures that can be reliably scored based on performance for the 2020 MIPS performance year. As a result, measures in the lowest deciles cannot get less than 3 measure achievement points. (Reliably scored means a national benchmark exists, sufficient case volume has been met, and the data completeness requirement has been met.)

What If I Chose a Measure That Doesn't Have an Historical Benchmark?

- Quality measures that can't be reliably scored against a benchmark, or quality measures without an historical benchmark, will receive 3 points (assuming the measure meets data completeness) unless a benchmark can be established with performance period data.
- If the measure does not also meet data completeness, it will receive 0 points (except for small practices, which would receive 3 measure achievement points).
- The above applies to measures across all collection types except for CMS Web Interface measures. and administrative claims measures. The CMS Web Interface measures that do not have a benchmark are not scored (included in the denominator) as long as the measure meets data completeness criteria.

Scoring

Examples

Example 1:

This example shows how to use the 2020 Quality Benchmarks to convert into measure achievement points. This scoring example assumes data completeness and case minimum have been met.

Measure 009: Anti-Depressant Medication Management, collected and reported as an eCQM.
Dr. Clark submits data for Measure 009 (eCQM) that results in a performance rate of 58.09% and 6.6 achievement points.

How?
This performance rate falls in Decile 6, which means a measure score of 6.0-6.9 points

Scoring Example 1.

Apply the following formula based on the measure performance and decile range:

$$\text{Achievement points} = X + \frac{(q-a)}{(b-a)}$$

$$\text{Achievement points} = 6 + \frac{(58.09-49.35)}{(64.59-49.35)}$$

$$\frac{(58.09-49.35)}{(64.59-49.35)} = 0.573490\ldots$$

Which is rounded to 0.6

$$\textbf{\textit{Achievement points}} = 6.6$$

X = decile #
q = performance rate
a = bottom of decile range
b = top of decile range

Note: Partial achievement points are rounded to the tenths digit for partial points between 0.01 to 0.89. Partial achievement points above 0.9 are truncated to 0.9.

Examples *(continued)*

Example 2:

This scoring example assumes case minimum has been met and data completeness of 60%.

Measure 112, Breast Cancer Screening, collected and reported as a MIPS CQM.
Lakeview Associates, a primary care clinic with 17 clinicians, submits data as a group for Measure 112 (MIPS CQM) that results in a performance rate of 95% and 0 achievement points.

Why?

This performance rate falls in Decile 8, which would normally mean a measure score of 8.0-8.9 points if case minimum and data completeness criteria is met. However, **the group did not meet data completeness criteria of 70% for 2020.** Measures that do not meet data completeness will earn 0 measure achievement points unless the group has a small practice designation (small practices will continue to earn 3 points).

In 2020, the data completeness criteria increased from 60% to 70%. For QCDR measures, MIPS CQMs, and eCQMs, this means a 70% sample of patients across all payers. For Medicare Part B Claims, it is 70% sample of all Medicare Part B patients. *There was no change in data completeness for CMS Web Interface measures.*

Scoring

Bonus Points

What is the end-to-end electronic reporting bonus?

You'll receive:

- **1 bonus point** per measure for reporting your quality data directly from your CEHRT any manual manipulation.
- These are capped at **10%** of your Quality performance category denominator.

NOTE FOR 2020: If you submit eCQMs, you'll need to use CEHRT to collect the eCQM data. The CEHRT used to collect the eCQM data will need to be certified to the 2015 Edition by the last day of the Quality performance period (December 31, 2020).

What is the bonus for submitting additional outcome/high priority measures beyond the 1 required?

You'll receive:

- **1 bonus point** for each additional high priority measure
- **2 bonus points** for each additional outcome and patient experience measure
- These bonus points are not available to the additional high priority measures required by the CMS Web Interface
- Bonus points are capped at **10%** of your Quality performance category denominator.

How do these measure bonus points work?

Bonus points are added to the Quality performance category achievement points (those earned based on performance) and each type of bonus is capped at 10% of the Quality performance category denominator.

For example:

- Individuals, groups, and virtual groups that are scored on 6 quality measures can earn a maximum of 60 points. This means they can earn **up to 6** end-to-end bonus points (10% of 60 points) and **up to 6** additional outcome/high-priority bonus points (10% of 60 points).

However, your Quality performance category score can never exceed 100%.

UPDATE 3/11/2021: CMS is suppressing the All-Cause Hospital Readmission measure under MIPS for the 2020 performance period. This means the measure will not be scored or attributed to a group or virtual group's quality performance category score. For more information on the 2020 suppressed measures, please refer to the 2020 Suppressed MIPS Quality Measures fact sheet.

Scoring

Bonus Points *(continued)*

Example:

Dr. Johnson is a MIPS eligible clinician at a primary care practice. He is participating as a group that reports 7 eCQM measures and 2 MIPS CQMs.

Measure Type	Collection Type	Achievement Points	Bonus Points	Total Points
Outcome Measure #1	MIPS CQM	8.2	N/A (Required)	8.2
Process Measure	eCQM	9.0	1 (End-to-End)	10.0
Process Measure	eCQM	9.1	1 (End-to-End)	10.1
Outcome Measure #2	eCQM	7.4	1 (End-to-End) 2 (Additional Outcome)	10.4
High Priority Measure	MIPS CQM	8.1	1 (Additional High Priority)	10.1
Process Measure	MIPS CQM	~~5.1~~ 0	N/A	~~5.1~~ 0
Outcome Measure #3	eCQM	~~3.5~~ 0	1 (End-to-End) 2 (Additional Outcome)	~~6.5~~ 3
Outcome Measure #4	eCQM	~~6.7~~ 0	1 (End-to-End) 2 (Additional Outcome)	~~9.7~~ 3
Process Measure	MIPS CQM	8.4	1 (End-to-End)	9.4
Totals		**50.2**	**12**	**60**

How is the small practice bonus applied in 2020?

6 bonus points will be added to the numerator of the quality performance category for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure. This bonus is not added to clinicians, groups, or virtual groups that are scored under facility-based scoring.

Even though the group was eligible to earn up to 12 bonus points resulting in a total score of 62.2, the score cannot exceed 100% so they will receive the maximum of 60 points in the quality performance category.

NOTE: Measure have been intentionally crossed out as they did not fall within the top 6 measures used for scoring. When determining which measures are included in the top 6, we select the highest scoring outcome measure (if no outcome measure was submitted, we will select the highest scoring high priority measure) and then select the next 5 highest scoring measures. However, we will include any bonus points from the remaining measures, as long as the 10% cap has not been reached for the applicable bonus.

Scoring

Improvement Scoring Overview

For the 2020 performance year, you can earn **up to 10 percentage points** based on the rate of your improvement in the Quality performance category from the year before.

You'll be evaluated for improvement scoring in 2020 when you:

- Participate fully in the Quality performance category for the current performance period (submit 6 measures/specialty measure set with at least 1 outcome/high priority measure OR submit as many measures as were available and applicable OR report all 10 measures in the CMS Web Interface; all measures must meet data completeness requirements); AND
- Have a Quality performance category achievement percent score based on reported measures for the previous performance period (Year 3, 2019); AND
- Submit data under the same identifier for the 2 performance periods, or if we can compare the data submitted for the 2 performance periods.

> Improvement scoring is not available for clinicians who are scored under facility-based measurement in the current performance period, or who were scored under facility-based measurement in the performance period immediately prior to the current MIPS performance period. For example, if your 2019 performance year Quality score is derived from facility-based measurement, you are not eligible for improvement scoring in the 2019 or 2020 performance years.

How Is Improvement Scoring Calculated?

Improvement scoring is calculated by comparing the Quality achievement percentage score from the previous period to the Quality performance category achievement percentage score in the current period. Measure bonus points are not included in improvement scoring.

$$\text{Improvement Percent Score} = \frac{\text{Increase Quality Performance Category Achievement Percent Score (From Prior Performance Period to Current Performance Period)}}{\text{Prior Performance Period Quality Performance Category Achievement Percent Score}} \times 10\%$$

Scoring

Improvement Scoring Example

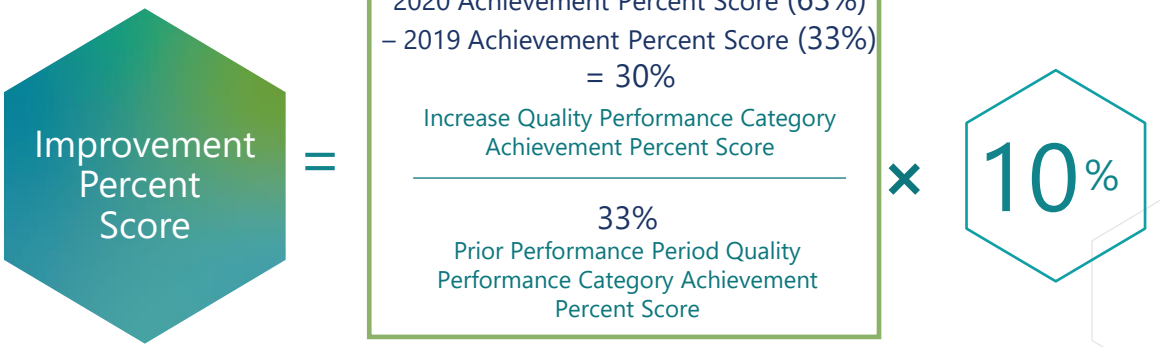
In 2019, Dr. Johnson earned 20 measure achievement points and 2 measure bonus points for reporting an additional outcome measure.

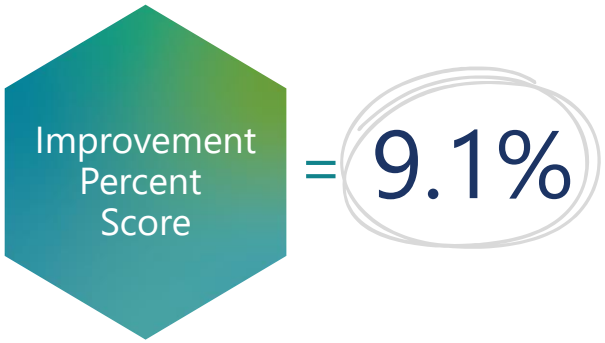
- 20 measure achievement points/60 total possible points = **33%**
- 2 bonus points excluded from the calculation

For the 2020 performance period, Dr. Johnson earned 38 measure achievement points and 6 measure bonus points.

- 38 measure achievement points/60 total possible points = **63%**
- 6 bonus points excluded from the calculation

The improvement percent score is **9.1%** which will be added to the percent score earned for reported measures. Please note that the improvement percent score cannot be negative and is capped at 10%.





Scoring

Calculating the Quality Performance Category Percent Score

The Quality Performance Category Percent Score is a product of the following equation:

$$\text{Quality Performance Category Percent Score (Not to exceed 100\%)} = \left(\frac{\text{Total Measure Achievement Points} + \text{Measure Bonus Points}}{\text{Total Available Measure Achievement Points*}} \times 100\% \right) + \text{Improvement Percent Score}$$

**Total available measure achievement points = # of required measures x 10*

Example:

$$\textbf{82.4\%}\ \text{Quality Performance Category Percent Score (Not to exceed 100\%)} = \left(\frac{44\ \text{Total Measure Achievement Points + Measure Bonus Points}}{60\ \text{Total Available Measure Achievement Points*}} = 0.733\ \text{Achievement Score} \times 100\% \right) + 9.1\%\ \text{Improvement Percent Score}$$

The Quality performance category percent score **for small practices** is a product of the following equation:

$$\text{Quality Performance Category Percent Score (Not to exceed 100\%)} = \left(\frac{\text{Total Measure Achievement Points} + \text{Measure Bonus Points} + \text{Small Practice Bonus (6 points)}}{\text{Total Available Measure Achievement Points*}} \times 100\% \right) + \text{Improvement Percent Score}$$

Scoring

Scoring Examples

Your Quality performance category percent score is multiplied by the category weight and then by 100 to determine the number of points that contribute to your final score.

Example 1:

The clinician, group or virtual group is scored on the quality, improvement activities and Promoting Interoperability performance categories, so the quality performance category is weighted at 55%.

82.4% x 55% x 100 = 49.44

Points under the Quality performance category contributing to the final score

Example 2:

The clinician, group or virtual group is only scored on the quality and improvement activities performance categories, so the quality performance category is weighted at 85%

82.4% x 85% x 100 = 70.04

Points under the Quality performance category contributing to the final score

REMINDER: We are reweighting the Cost performance category to 0% for all MIPS eligible clinicians regardless of participation as an individual, group, virtual group or APM Entity. When no additional reweighting applies, the 2020 MIPS performance category weights are as follows: Quality: 55%, Cost: 0%, Improvement Activities: 15%, Promoting Interoperability: 30%.

Scoring

Maximum Points Available in the Quality Performance Category

Your Quality performance category score is determined by dividing the achievement points that you receive for the measures you submitted (and any bonus points) by the maximum number of achievement points that you could receive, which will depend on your collection type. The maximum number of points available can vary.

Measure Type	Maximum Points Available
eCQMs, Medicare Part B Claims Measures, MIPS CQMs, and QCDR Measures	• Individual – 60 points • Groups/virtual groups/APM Entities – 60 points
CMS Web Interface Measures	• Groups /virtual groups – 70 points for CMS Web Interface measures • Groups/virtual groups/APM Entities – 80 points for CMS Web Interface measures + CAHPS for MIPS Survey

UPDATE 3/11/2021: CMS is suppressing the All-Cause Hospital Readmission Measure under MIPS for the 2020 performance period. This means the measure will not be scored or attributed to a group or virtual group's quality performance category score. For more information on the 2020 suppressed measures, please refer to the 2020 Suppressed MIPS Quality Measures fact sheet.

Facility-Based Measurement Scoring

Your Facility-based clinicians, groups and virtual groups may have the option to use facility-based measurement scores for their Quality and Cost performance category scores.

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

- You are identified as facility-based; and
- You are assigned to a facility with a FY 2021 Hospital Value-Based Purchasing (VBP) Program score; and
- The Hospital VBP score results in a higher combined score for the Quality and Cost performance categories than any MIPS Quality measure data you submit and MIPS Cost measure data we calculate for you.

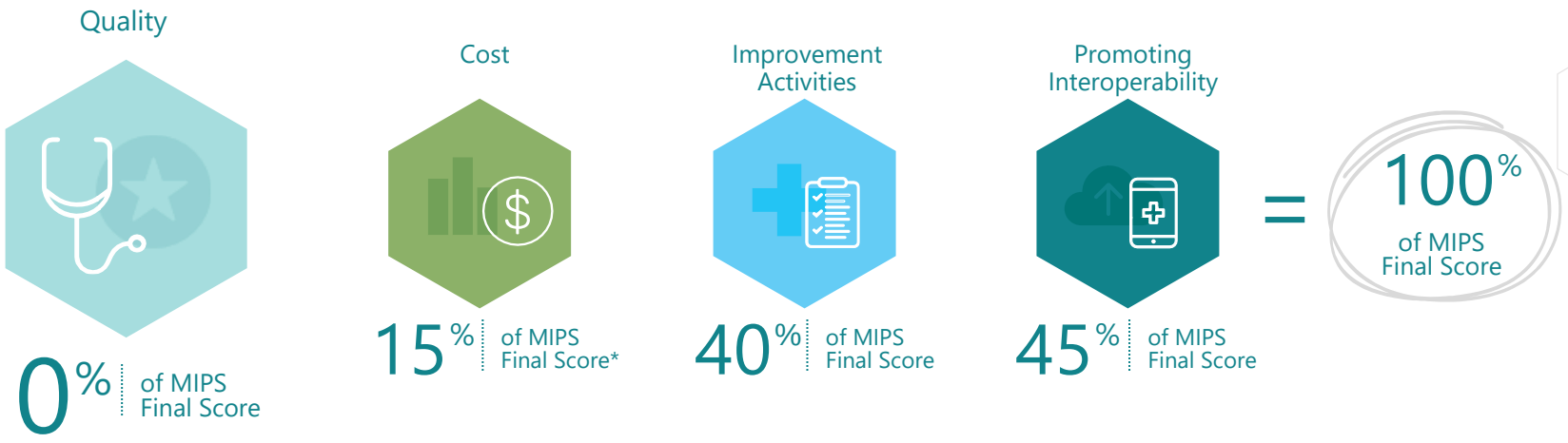
To learn more, review the 2020 Facility-Based Quick Start Guide.

Scoring

Reweighting the Quality Performance Category

If you don't submit data for the Quality performance category because there are no quality measures available to you or your 2020 Extreme & Uncontrollable Circumstances Exception request to reweight the Quality performance category is approved, you won't earn any points in this performance category, and weight will be redistributed to other performance categories.

The breakdown for individuals, groups, or virtual groups:



**This breakdown assumes that you/your group/your virtual group can be scored for the Cost performance category.*

REMINDER: We are reweighting the Cost performance category to 0% for all MIPS eligible clinicians regardless of participation as an individual, group, virtual group or APM Entity. When no additional reweighting applies, the 2020 MIPS performance category weights are as follows: Quality: 55%, Cost: 0%, Improvement Activities: 15%, Promoting Interoperability: 30%. We are leaving the content in this guide as-is for historical reference.

Help, Resources, Glossary, and Version History

Help, Resources, Glossary, and Version History

Where Can You Go for Help?

Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 a.m.-8:00 p.m. Eastern Time or by e-mail at: QPP@cms.hhs.gov.

- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Connect with your local technical assistance organization. We provide no-cost technical assistance to small, underserved, and rural practices to help you successfully participate in the Quality Payment Program.

Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out resources available in the QPP Resource Library.

Help, Resources, Glossary, and Version History

Additional Resources

The following resources are available on the QPP Resource Library:

- 2020 MIPS Quick Start Guide
- 2020 Quality Quick Start Guide
- 2020 Eligibility and Participation Quick Start Guide
- 2020 Part B Claims Reporting Quick Start Guide
- 2020 Quality Benchmarks
- 2020 Cross-Cutting Quality Measures
- 2020 Qualified Clinical Data Registries (QCDRs) Qualified Posting
- 2020 Qualified Registries Qualified Posting
- 2020 QPP Final Rule - Updates for QCDRs and Registries
- 2020 Self-Nomination Toolkit for QCDRs & Registries
- 2020 QCDR Measure Specifications
- 2020 CMS Web Interface Measure Specifications and Supporting Documents
- 2020 Clinical Quality Measure Specifications and Supporting Documents
- 2020 Medicare Part B Claims Measure Specifications and Supporting Documents
- 2020 SSP and QPP Interactions Guide
- 2020 MIPS APM Scoring Resources
- CMS Current Emergencies Webpage

Help, Resources, Glossary, and Version History

Glossary

Help, Resources, Glossary, and Version History

Version History

If we need to update this document, changes will be identified here.

Date	Change Description
6/21/2021	Updated content to reflect that the cost performance category will be weighted at 0% for all MIPS eligible clinicians in the 2020 performance year.
3/11/2021	• Updated COVID-19 slide to reference the automatic extreme and uncontrollable circumstances policy and the deadline extension for the exception application. • Updated slides 18, 28, 33, and 39 to account for CMS's decision to suppress the All-Cause Hospital Readmission measure from MIPS scoring for the 2020 MIPS performance period. • Updated CAHPS Benchmark information on slide 28. • Updated scoring example on slide 34 to account for suppression of All-Cause Hospital Readmission measure for the 2020 performance period. • Corrected eCQM information on slide 19 ("what you need to know" content erroneously referenced MIPS CQM information) • Corrected slide 38 to reflect the new category weight when cost is reweighted, (10% is redistributed to quality and 5% to Promoting Interoperability)
10/21/2020	Fixed typo on page 24 to confirm that Medicare Part B Claims data must be processed by your MAC and received by CMS by March 1, 2021.
10/5/2020	Original posting

Appendix

Appendix

Appendix: Measure Removal Finalized in the CY2020 PFS Final Rule

Quality ID	CMS eCQM ID / NQF #	Measure Title	Collection Type(s)
046	NQF #0097	Medication Reconciliation Post-Discharge	Medicare Part B Claims, MIPS CQM
051	NQF #0091	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	Medicare Part B Claims, MIPS CQM
068	N/A	Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	MIPS CQM
091	NQF #0653	Acute Otitis Externa (AOE): Topical Therapy	Medicare Part B Claims, MIPS CQM
109	N/A	Osteoarthritis (OA): Function and Pain Assessment	Medicare Part B Claims, MIPS CQM
131	NQF #0420	Pain Assessment and Follow-Up	Medicare Part B Claims, MIPS CQM
160	CMS 52v8	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	eCQM
165	NQF #0130	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	MIPS CQM
166	NQF #0131	Coronary Artery Bypass Graft (CABG): Stroke	MIPS CQM
179	N/A	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	MIPS CQM
192	CMS 132v8 / NQF #0564e	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	eCQM, MIPS CQM
223	NQF #0428	Functional Status Change for Patients with General Orthopedic Impairments	MIPS CQM
255	N/A	Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure	Medicare Part B Claims, MIPS CQM
262	N/A	Image Confirmation of Successful Excision of Image- Localized Breast Lesion	MIPS CQM
271	N/A	Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment	MIPS CQM
325	N/A	Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	MIPS CQM
328	NQF #1667	Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL	MIPS CQM
329	N/A	Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis	MIPS CQM
330	N/A	Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days	MIPS CQM
343	N/A	Screening Colonoscopy Adenoma Detection Rate	MIPS CQM
345	NQF #1543	Rate of Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) Who Are Stroke Free or Discharged Alive	MIPS CQM
347	NQF #1534	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) Who Are Discharged Alive	MIPS CQM
352	N/A	Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet	MIPS CQM

Appendix

Appendix: Measure Removal Finalized in the CY2020 PFS Final Rule *(continued)*

Quality ID	CMS eCQM ID / NQF #	Measure Title	Collection Type(s)
353	N/A	Total Knee Replacement: Identification of Implanted Prosthesis in Operative Report	MIPS CQM
361	N/A	Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry	MIPS CQM
362	N/A	Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-up and Comparison Purposes	MIPS CQM
371	CMS 160v8 / NQF #0712e	Depression Utilization of the PHQ-9 Tool	eCQM
372	CMS 82v7	Maternal Depression Screening	eCQM
388	N/A	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy	MIPS CQM
403	N/A	Adult Kidney Disease: Referral to Hospice	MIPS CQM
407	N/A	Appropriate Treatment of Methicillin-Susceptible Staphylococcus Aureus (MSSA) Bacteremia	Medicare Part B Claims, MIPS CQM
411	NQF #0711	Depression Remission at Six Months	MIPS CQM
417	NQF #1523	Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) Where Patients are Discharged Alive	MIPS CQM
428	N/A	Pelvic Organ Prolapse: Preoperative Assessment of Occult Stress Urinary Incontinence	MIPS CQM
442	NQF #0071	Persistence of Beta-Blocker Treatment After a Heart Attack	MIPS CQM
446	NQF #0733	Operative Mortality Stratified by the Five STS-EACTS Mortality Categories	MIPS CQM
449	NQF #1857	HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies	MIPS CQM
454	N/A	Percentage of Patients who Died from Cancer with More than One Emergency Department Visit in the Last 30 Days of Life – inverse measure	MIPS CQM
456	NQF #0215	Percentage of Patients who Died from Cancer Not Admitted to Hospice – inverse measure	MIPS CQM
467	N/A	Developmental Screening in the First Three Years of Life	MIPS CQM
474	N/A	Zoster (Shingles) Vaccination	MIPS CQM