# Merit-based Incentive Payment System Measures

For Doctors in Cardiology

Visit QPP.CMS.gov to understand program basics, including submission timelines and how to participate.

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Mountain-Pacific Quality Health

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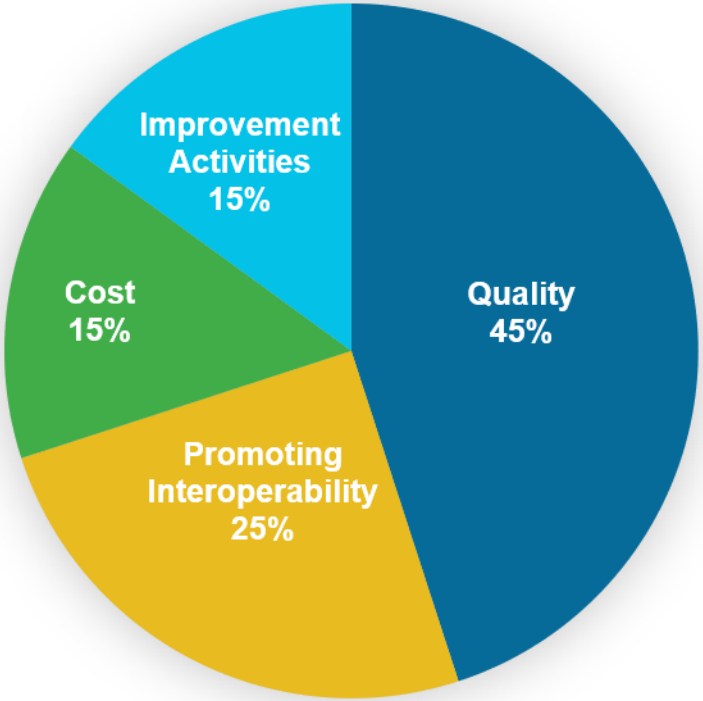
## What is MIPS?

The Merit-based Incentive Payment System (MIPS) is one of the two tracks of the Medicare Quality Payment Program (QPP), which implements provisions of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA).

## What must be submitted to successfully participate in MIPS?

If you are participating in QPP through MIPS, you must submit a full year of Quality measures, full year of Cost measures, 90 days of Improvement Activities measures and 90 days of Improvement Activities measures. Your MIPS payment adjustment in 2022 will be based on submitting data and your performance for the following MIPS categories in 2020:




- **Quality**
- **Promoting Interoperability**
- **Improvement Activities**
- **Cost**

# Quality Category - 45%

**The reporting period for the Quality category is a 12-month period (January 1 through December 31, 2020). During this 12-month period, six measures must be reported and at least one outcome measure or another high-priority measure.**

Clinicians may choose measures on which they may report from a list. Some include:

- **Quality ID-005**: Heart Failure (HF): Angiotensin-converting enzyme (ACE) Inhibitor, Angiotensin-Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- **Quality ID-006**: Coronary Arter Disease (CAD): Antiplatelet Therapy
- **Quality ID-007**: CAD: Beta Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Ejection Fraction (LVEF) < 40%
- **Quality ID-008**: HF: Beta Blocker Therapy for LVSD
- **Quality ID-047**: Advance Care Plan
- **Quality ID-118**: CAD: ACE Inhibitor or ARB Therapy—Diabetes or LVEF < 40%
- **Quality ID-128**: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- **Quality ID-130**: Documentation of Current Medication in Medical Record
- **Quality ID-226**: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- **Quality ID-236**: Controlling High Blood Pressure
- **Quality ID-238**: Use of High-Risk Medications in the Elderly
- **Quality ID-243**: Cardiac Rehabilitation Patient Referral from an Outpatient Setting

**Red: high-priority measures**

- **Quality ID-317**: Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented
- **Quality ID-322**: Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients
- **Quality ID-323**: Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing after Percutaneous Coronary Intervention (PCI)
- **Quality ID-324**: Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients
- **Quality ID-326**: Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy
- **Quality ID-344**: Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2)
- **Quality ID-374**: Closing the Referral Loop: Receipt of Specialist Report
- **Quality ID-402**: Tobacco Use and Help with Quitting Among Adolescents
- **Quality ID-431**: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- **Quality ID-438**: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- **Quality ID-441**: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)

**Learn more at qpp.cms.gov.**

# Improvement Activities - 15%

**The reporting period for the Improvement Activities category is a 90-day to a full-calendar-year period (January 1 through December 31, 2020).**

Clinicians choose activities in which they may participate from a list. Some activities include:

- **IA_AHE_1**: Engage new Medicaid patients and follow-up
- **IA_BE_6:** Collect and follow up on patient experience and satisfaction data
- **IA_BE_20**: Implementation of condition-specific chronic disease self-management support programs
- **IA_EPA_1**: Provide 24/7 access to clinicians/groups who have real-time access to patient's medical record
- **IA_EPA_3**: Collection and Use of Patient Experience and Satisfaction Data on Access
- **IA_PM_2**: Implement anticoagulant management improvements
- **IA_PM_7**: Use Qualified Clinical Data Registry (QCDR) for feedback reports that incorporate population health
- **IA_PM_21**: Advance care planning
- **IA_PSPA_6**: Consultation of the Prescription Drug Monitoring Program (PDMP)
- **IA_PSPA_22**: Centers for Disease Control and Prevention (CDC) training on CDC's Guideline for Prescribing Opioids for Chronic Pain

**Blue: medium-weighted measures**
**Green: high-weighted measures**

# $ Cost - 15%

## Why report cost?

For the 2020 performance year, the Cost category is 15 percent of the MIPS final score. Reporting on Cost measures in 2020 will help you understand the Cost category before the percentage increases in future performance years.

## No Cost category? What happens?

If you do not meet either or the case minimums for either measure of the Cost category, it will be reweighted to the Quality category. This will then result in the Quality category being worth 60 percent of your MIPS final score, instead of 45 percent.

## How will you be scored?

- If only one measure can be scored, that score will be the performance score.
- There is no reporting required. The Centers for Medicare & Medicaid Services (CMS) automatically calculates from claims submitted for payment.
- No score will be given to eligible clinicians who are not attributed any cost measures because of case minimum requirement or lack of benchmark.

## Medicare Spend per Beneficiary Clinician (35 case minimum)

- Risk-adjusted Part A and B costs per inpatient admission
- Attributed based on service volume during hospitalization
- Assesses the cost of care for services related to qualifying in patient hospital stay (immediately prior to, during and after) for Medicare patient
- Includes all Part A and Part B claims

## Total per Capita Cost (20 case minimum)

- Risk-adjusted per capita Part A and B costs
- Attributed based on primary care service volume
- Assesses the primary care clinician's overall care for a Medicare patient during the performance period

## Episode-Based Measures

- Electronic Outpatient Percutaneous Coronary Intervention (PCI)
- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Limb Ischemia
- Routine Cataract Removal with Intraocular Lens (IOL) Implantation
- Screening/Surveillance Colonoscopy
- Acute Kidney Injury Requiring New Inpatient Dialysis
- Elective Primary Hip Arthroplasty
- Femoral or Inguinal Hernia Repair
- Hemodialysis Access Creation
- Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
- Lumpectomy Partial Mastectomy, Simple Mastectomy
- Non-Emergent Coronary Artery Bypass Graft (CABG)
- Renal or Ureteral Stone Surgical Treatment
- Intracranial Hemorrhage or Cerebral Infarction
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infraction (STEMI) with Percutaneous Coronary Intervention (PCI)
- Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
- Lower Gastrointestinal Hemorrhage (applies to groups only)

$$\text{COST PERFORMANCE} = \frac{\text{Total points scored on each measure}}{\text{Total possible points available}}$$

**Learn more at qpp.cms.gov.**

# Promoting Interoperability (PI) - 25%

The Promoting Interoperability (PI) performance category score is now performance-based (100 points with optional 10 bonus points). The score is based on "objectives" that have measures included in them.

### Submit YES to:

- Prevention of Information Blocking Attestation
- Office of the National Coordinator (ONC) Direct Review Attestation
- Security Risk Analysis (SRA) Completion:
  - No score attached
  - Must be during calendar year in which reporting
  - Required to receive PI score

### Certified Electronic Health Record Technology (CEHRT) Requirements:

- 2015 Edition
- Be in place for the 90-day reporting period chosen
- Be certified to 2015 edition by the last day of the selected reporting period

### How is PI scored?

| Provider-to-Patient Exchange | |
|---|---|
| **Measure Name** | **Points** |
| Provide Patient Electronic Access to Their Health Information | 40 |

| Public Health and Clinical Data Exchange (Choose 2 – Reported with "YES" or "NO.") | |
|---|---|
| **Measure Name** | **Points** |
| Immunization Registry Reporting | 10 |
| Electronic Case Reporting | 10 |
| Public Health Registry Reporting | 10 |
| Syndromic Surveillance Reporting | 10 |
| Clinical Data Registry Reporting | 10 |

| Electronic Prescribing (Green measures are bonus measures.) | |
|---|---|
| **Measure Name** | **Points** |
| E-Prescribing | 10 |
| Query of Prescription Drug Monitoring Drug Program (PDMP) | 5 |

| Health Information Exchange | |
|---|---|
| **Measure Name** | **Points** |
| Support Electronic Referral Loops by Sending Health Information | 20 |
| Support Electronic Referral Loops by Receiving and Incorporating Health Information | 20 |

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