Quality Payment PROGRAM

CY 2019 Physician Fee Schedule (PFS) Final Rule: QCDR and Qualified Registry (New and Updated) Policies

December 18, 2018

The CY 2019 PFS Final Rule has been released and is available here:
Below is a summary of changes which may impact your QCDR or Qualified Registry for the 2019 and/or 2020 performance period of MIPS.

2019 Performance Period

As stated in the CY 2019 PFS Final Rule for the Quality Payment Program, CMS policy prohibits non-U.S. citizens from accessing CMS IT systems, and also requires all CMS program data to be retained in accordance with U.S. Federal policy, specifically National Institute of Standards and Technology (NIST) Special Publication (SP) 800–63, which outlines enrollment and identity proofing requirements (levels of assurance) for federal IT system access. Access to the Quality Payment Program would necessitate passing a remote or in-person Federated Identity Proofing process (that is, Equifax or equivalent). A non-U.S. based third party intermediary's potential lack of a SSN, TIN, U.S. based address, and other elements required for identity proofing and identity verification would impact their ability to pass the necessary background checks. An inability to pass identity proofing may limit or fully deny access to the Quality Payment Program if the intent is to interact with the Quality Payment Program outside of the U.S. for the purposes of reporting and storing data.

Please note that this policy is not specific to the Quality Payment Program, but is implemented across programs at CMS.
New MIPS terms for 2019 are as follows:

- **Collection Type** is a set of quality measures with comparable specifications and data completeness criteria including, as applicable: electronic clinical quality measures (eCQMs); MIPS clinical quality measures (CQMs) (formerly referred to as "Registry measures"); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey measure; and administrative claims measures.
- **Submitter Type** is the MIPS eligible clinician, group, or third party intermediary acting on behalf of a MIPS eligible clinician or group, as applicable, that submits data on measures and activities.
- **Submission Type** is the mechanism by which the submitter type submits data to CMS, including, as applicable: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface. There is no submission type for cost data because the data is collected and calculated by CMS from administrative claims data submitted for payment.

Quality Performance Category

Changes for 2019 include:

- A high priority measure is now defined as an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure. Outcome measures include intermediate-outcome and patient-reported outcome measures.
- High priority bonus points are discontinued to CMS Web Interface reporters.
- Medicare Part B claims measures can only be submitted by clinicians in a small practice (15 or fewer eligible clinicians), whether participating individually or as a group.
- The definition and lifecycle for topped out quality measures remain the same (CY 2018 Quality Payment Program final rule: 82 FR 53637 through 53640).
    - After a measure has been identified as topped out for 3 consecutive years, CMS may propose to remove the measure through notice and comment rule-making. If finalized through rule-making, the measure would be removed in the 4th year and no longer be available for reporting.
    - Extremely topped-out measures occur when the average mean performance is within the 98th to 100th percentile range. These measures may be proposed for removal in the next rule-making cycle and will not follow the 4-year lifecycle for other topped-out measures.
    - 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 self-nomination process, it may not be approved for the applicable performance period.
- Quality measure specifications, including QCDR measures, need to include ICD-10 codes. Beginning with the 2018 MIPS performance period, measures significantly impacted by ICD–10 updates, as determined by CMS, will be assessed based only on the first 9 months of the 12-month performance period, and the list of measures requiring a 9-month assessment process will be published on the CMS website.
- Policy was added for quality measures impacted by clinical guidelines changes:
    - CMS will identify measures for which following the guidelines in the existing measure specification could result in patient harm or otherwise provide misleading results as to good quality care.
    - Clinicians who are following the revised clinical guidelines will still need to submit the impacted measure. The total available measure achievement points in the denominator will be reduced by 10 points and the numerator of the impacted measure will result in zero points.

MIPS Quality Measures that are Added/Removed

- **The following MIPS quality measures were added as new measures in the 2019 Performance Period (8 Total):**

MIPS Quality ID	Indicator	Collection Type	Measure Type	MIPS Measure Name
468	High Priority/ Opioid	MIPS CQMs specifications	Process	Continuity of Pharmacotherapy for Opioid Use Disorder
469	High Priority/ Patient Reported Outcome	MIPS CQMs specifications	Patient Reported Outcome	Average Change in Functional Status Following Lumbar Spine Fusion Surgery
470	High Priority/ Patient Reported Outcome	MIPS CQMs specifications	Patient Reported Outcome	Average Change in Functional Status Following Total Knee Replacement Surgery
471	High Priority/ Patient Reported Outcome	MIPS CQMs specifications	Patient Reported Outcome	Average Change in Functional Status Following Lumbar Discectomy Laminotomy Surgery
472	High Priority/ Appropriate Use	eCQM specifications	Process	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture
473	High Priority/ Patient Reported Outcome	MIPS CQMs specifications	Patient Reported Outcome	Average Change in Leg Pain Following Lumbar Spine Fusion Surgery
474		MIPS CQMs specifications	Process	Zoster (Shingles) Vaccination
475		MIPS CQMs specifications	Process	HIV Screening

The following MIPS quality measures were removed in the 2019 Performance Period (26 Total):

MIPS Quality ID	MIPS Measure Name	Reason for Removal
018	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Duplicative of Measure 019: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care which is a high priority measure
043	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	Extremely Topped-out
099	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	Extremely Topped-out
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	Extremely Topped-out
122	Adult Kidney Disease: Blood Pressure Management	Measure not planned to be updated to reflect current clinical guidelines
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	Measure neither assesses a clinical outcome nor one of the defined MIPS high priority areas
156	Oncology: Radiation Dose Limits to Normal Tissues	Extremely topped-out
163	Comprehensive Diabetes Care: Foot Exam	Duplicative of Measure 126: Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Duplicative of a component within Measure 441: Ischemic Vascular Disease: All or None Outcome Measure
224	Melanoma: Avoidance of Overutilization of Imaging Studies	Extremely topped-out
251	Quantitative Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients	Extremely topped-out
257	Statin Therapy at Discharge after Lower Extremity Bypass (LEB)	Clinical concept captured within Measure 438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
276	Sleep Apnea: Assessment of Sleep Symptoms	Duplicative of Measure 277: Sleep Apnea: Severity Assessment at Initial Diagnosis

MIPS Quality ID	MIPS Measure Name	Reason for Removal
278	Sleep Apnea: Positive Airway Pressure Therapy Prescribed	Duplicative of Measure 279: Sleep Apnea: Severity Assessment of Adherence to Positive Airway Pressure Therapy
263	Preoperative Diagnosis of Breast Cancer	Limited opportunity to improve clinical outcomes and is not a high priority area
327	Pediatric Kidney Disease: Adequacy of Volume Management	Limited opportunity to improve clinical outcomes and is not a high priority area
334	Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)	Extremely topped-out
359	Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging	Duplicative of Measure 361: Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry
363	Optimizing Patient Exposure to Ionizing Radiation: Search for Prior Computed Tomography (CT) Studies Through a Secure, Authorized, Media-Free, Shared Archive	Quality action does not completely attribute to the radiologist submitting the measure or to improved outcomes
367	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Measure not linked to improved outcomes
369	Pregnant women that had HBsAg testing:	Measure steward no longer maintaining the measure and measure does not evaluate for care with positive testing results
373	Hypertension: Improvement in Blood Pressure	Duplicative of Measure 236: Controlling High Blood Pressure
423	Perioperative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy	Clinical concept captured within Measure 441: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)
426	Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit (PACU)	Extremely topped-out
427	Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU)	Extremely topped-out
447	Chlamydia Screening and Follow-up	Duplicative of Measure 310: Chlamydia Screening for Women

Improvement Activities Performance Category

- For the 2019 Performance Period, six new IA were added, five IA had revised activity descriptors, and one IA was deleted.
- MIPS eligible clinicians or groups must submit data on MIPS improvement activities in one of the following manners: Qualified registries; EHR submission mechanisms; QCDR; CMS Web Interface; or attestation.
- The Promoting Interoperability bonus is eliminated for improvement activities.

The following MIPS Improvement Activities were added in the 2019 Performance Period (6 Total):

New IA for 2019	Subcategory Name	Activity Name	Activity Description
IA_CC_18	Care Coordination	Relationship-Centered Communication	In order to receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychological Association (APA) Collaborative Care Model training program available as part of the Centers for Medicare & Medicaid Services (CMS) Transforming Clinical Practice Initiative (TCPI), available to the public, in order to implement a collaborative care management approach that provides comprehensive training in the integration of behavioral health into the primary care practice.
IA_BE_24	Beneficiary Engagement	Financial Navigation Program	In order to receive credit for this activity, MIPS eligible clinicians must attest that their practice provides financial counseling to patients or their caregiver about costs of care and an exploration of different payment options. The MIPS eligible clinician may accomplish this by working with other members of their practice (for example, financial counselor or patient navigator) as part of a team-based care approach in which members of the patient care team collaborate to support patient- centered goals. For example, a financial counselor could provide patients with resources with further information or support options, or facilitate a conversation with a patient or caregiver that could address concerns. This activity may occur during diagnosis stage, before treatment, during treatment, and/or during survivorship planning, as appropriate.

New IA for 2019	Subcategory Name	Activity Name	Activity Description
IA_PSPA_31	Patient Safety and Practice Assessment	Patient Medication Risk Education	In order to receive credit for this activity, MIPS eligible clinicians must provide both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use for patients who are prescribed both benzodiazepines and opioids. Education must be completed for at least 75 percent of qualifying patients and occur: (1) at the time of initial co-prescribing and again following greater than 6 months of co- prescribing of benzodiazepines and opioids, or (2) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.
IA_PSPA_32	Patient Safety and Practice Assessment	Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support	In order to receive credit for this activity, MIPS eligible clinicians must utilize the Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain via clinical decision support (CDS). For CDS to be most effective, it needs to be built directly into the clinician workflow and support decision making on a specific patient at the point of care. Specific examples of how the guideline could be incorporated into a CDS workflow include, but are not limited to: electronic health record (EHR)-based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.
IA_AHE_7	Achieving Health Equity	Comprehensive Eye Exams	In order to receive credit for this activity, MIPS eligible clinicians must promote the importance of a comprehensive eye exam, which may be accomplished by providing literature and/or facilitating a conversation about this topic using resources such as the “Think About Your Eyes” campaign and/or referring patients to resources providing no-cost eye exams, such as the American Academy of Ophthalmology’s EyeCare America and the American Optometric Association’s VISION USA. This activity is intended for: (1) non-ophthalmologists / optometrist who refer patients to an ophthalmologist/optometrist; (2) ophthalmologists/optometrists caring for underserved patients at no cost; or (3) any clinician providing literature and/or resources on this topic. This activity must be targeted at underserved and/or high- risk populations that would benefit from engagement regarding their eye health with the aim of improving their access to comprehensive eye exams.

New IA for 2019	Subcategory Name	Activity Name	Activity Description
IA_BMH_10	Behavioral and Mental Health	Completion of Collaborative Care Management Training Program	In order to receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychological Association (APA) Collaborative Care Model training program available as part of the Centers for Medicare & Medicaid Services (CMS) Transforming Clinical Practice Initiative (TCPI), available to the public, in order to implement a collaborative care management approach that provides comprehensive training in the integration of behavioral health into the primary care practice.

The following MIPS Improvement Activities were revised in the 2019 Performance Period (5 Total):

Revised IA for 2019	Subcategory Name	Activity Name	Activity Description
IA_PM_13	Population Management	Chronic care and preventative care management for empaneled patients	In order to receive credit for this activity,
IA_CC_10	Care Coordination	Care transition documentation practice improvements	In order to receive credit for this activity, a MIPS eligible clinician must document practices/processes for care transition with documentation of how a MIPS eligible clinician or group carried out an action plan for the patient with the patient's preferences in mind (that is, a "patient-centered" plan) during the first 30 days following a discharge. Examples of these practices/processes for care transition include: staff involved in the care transition; phone calls conducted in support of transition; accompaniments of patients to appointments or other navigation actions; home visits; patient information access to their medical records; real time communication between PCP and consulting clinicians; PCP included on specialist follow-up or transition communications.

Revised IA for 2019	Subcategory Name	Activity Name	Activity Description
IA_PSPA_2	Practice Safety & Practice Assessment	Participation in MOC Part IV	In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. Maintenance of Certification (MOC) Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results. Some examples of activities that can be completed to receive MOC Part IV credit are: the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program; specialty-specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules.
IA_PSPA_8	Practice Safety & Practice Assessment	Use of patient safety tools	In order to receive credit for this activity, a MIPS eligible clinician must use tools that assist specialty practices in tracking specific measures that are meaningful to their practice. Some examples of tools that could satisfy this activity are: a surgical risk calculator; evidence based protocols, such as Enhanced Recovery After Surgery (ERAS) protocols; the Centers for Disease Control (CDC) Guide for Infection Prevention for Outpatient Settings predictive algorithms; and the opiate risk tool (ORT) or similar tool.
IA_PSPA_17	Practice Safety & Practice Assessment	Implementation of analytic capabilities to manage total cost of care for practice population	In order to receive credit for this activity, a MIPS eligible clinician must conduct or build the capacity to conduct analytic activities to manage total cost of care for the practice population. Examples of these activities could include: • Train appropriate staff on interpretation of cost and utilization information; • Use available data regularly to analyze opportunities to reduce cost through improved care. An example of a platform with the necessary analytic capability to do this is the American Society for Gastrointestinal (GI) Endoscopy's GI Operations Benchmarking Platform.

The following Improvement Activities were removed in the 2019 Performance Period (1 Total):

Removed IA for 2019	Subcategory Name	Activity Name	Activity Description	Reason for Removal
IA_PM_9	Population Management	Participation in population health research	Participation in research that identifies interventions, tools or processes that can improve a targeted patient population.	Duplicative to IA_PM_17: Participation in federally funded research that identifies interventions, tools, or processes that can improve a targeted patient population.

Promoting Interoperability Performance Category

MIPS PI Measures that are Added/Renamed/Removed

The following MIPS PI measures were added as new measures in the 2019 Performance Period (3 Total):

MIPS PI ID	MIPS PI Measure Name
PI_EP_2	Query of Prescription Drug Monitoring Program (PDMP)
PI_EP_3	Verify Opioid Treatment Agreement
PI_HIE_4	Support Electronic Referral Loops by Receiving and Incorporating Health Information*

*combined Request/Accept Summary of Care and Clinical Information Reconciliation measures

The following MIPS PI measures were renamed in the 2019 Performance Period (2 Total):

MIPS PI ID	MIPS PI Measure Name
PI_HIE_1	Support Electronic Referral Loops by Sending Health Information*
PI_PEA_1	Provide Patients Electronic Access to Their Health Information**

*renamed Send a Summary of Care measure
**renamed Provide Patient Access measure

The following MIPS PI measures were removed in the 2019 Performance Period (15 Total):

MIPS Quality ID	MIPS PI Measure Name
PI_PEA_2	Patient-Specific Education
PI_CCTPE_2	Secure Messaging
PI_CCTPE_1	View, Download, or Transmit (VDT)
PI_CCTPE_3	Patient-Generated Health Data
	PI Transition Measures
PI_TRANS_EP_1	Electronic Prescribing
PI_TRANS_HIE_1	Health Information Exchange
PI_TRANS_PHCDRR_1	Immunization Registry Reporting
PI_TRANS_MR_1	Medication Reconciliation
PI_TRANS__PSE_1	Patient-Specific Education
PI_TRANS_PEA_1	Provide Patient Access
PI_TRANS_SM_1	Secure Messaging
PI_TRANS_PPHI_1	Security Risk Analysis
PI_TRANS_PHCDRR_3	Specialized Registry Reporting
PI_TRANS_PHCDRR_2	Syndromic Surveillance Reporting
PI_TRANS_PEA_2	View, Download or Transmit (VDT)

PI Performance Category Certified Electronic Health Record Technology (CEHRT) Requirements

For the PI performance category, MIPS eligible clinicians are required to use 2015 Edition CEHRT beginning with the 2019 MIPS performance period to make it easier for:

- Patients to access their data
- Patient information to be shared between doctors and other health care providers

Scoring

In the CY 2019 PFS final rule, under the PI performance category, a new approach for scoring that moves away from the base, performance, and bonus score methodology currently established was finalized. This new approach removes the availability of a bonus score for attesting to completing one or more specified improvement activities using CEHRT beginning with the CY 2019 performance period and future years. Below is a table of the new scoring methodology.

Scoring Methodology for the MIPS Performance Period in 2019:

Objectives	Measures
e-Prescribing	• e-Prescribing (10 points) • *Bonus:* Query of Prescription Drug Monitoring Program (PDMP) (5 points bonus) • *Bonus:* Verify Opioid Treatment Agreement (5 points bonus)
Health Information Exchange	• Support Electronic Referral Loops by Sending Health Information (20 points) • Support Electronic Referral Loops by Receiving and Incorporating Health Information (20)points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information (40 points)
Public Health and Clinical Data Exchange	Choose two of the following (10 points): Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting

Other Program Impacts

Third Party Intermediaries:

- CMS finalized to define a third party intermediary as an entity that has been approved to submit data on behalf of a MIPS eligible clinician, group, or virtual group for one or more of the quality, improvement activities, and Promoting Interoperability performance categories.
- A QCDR, qualified registry, health IT vendor, or CMS-approved survey vendor are considered third party intermediaries.

Remedial Action and Termination of Third Party Intermediaries

- The terms “probation” and “disqualification for third party intermediaries” have been renamed to “remedial action” and “termination of third party intermediaries”
- CMS may take one or more of the following remedial actions if we determine that a third party intermediary has ceased to meet one or more of the applicable third party intermediary criteria for approval or has submitted data that is inaccurate, unusable, or otherwise compromised:
    - We will require the third party intermediary to submit by a deadline specified by CMS a CAP that addressed the identified deficiencies or data issue, including the actions it will take to prevent the deficiencies or data issues from recurring;

    - Or we will publicly disclose the entity's data error rate on the CMS website until the data error rate falls below 3 percent.
- CMS may immediately or with advance notice terminate the ability of a third party intermediary to submit MIPS data on behalf of a MIPS eligible clinician, group, or virtual group for one or more of the following reasons:
    - CMS has grounds to impose remedial action
    - CMS has not received a CAP within the specified time period
    - The CAP is not accepted by CMS
    - The third party intermediary fails to correct the deficiencies or data errors by the date specified by CMS.
- CMS may determine that submitted data is inaccurate, unusable, or otherwise compromised if it includes without limitation:
    - TIN/NPI mismatches
    - Formatting issues
    - Calculation errors
    - Data audit discrepancies
    - Affects more than 3 percent of the total number of MIPS eligible clinicians or group for which data was submitted by the third party intermediary.

<u>New Clinician Types to be added for the 2019 Performance Period:</u>

- Physical therapists
- Occupational therapists
- Qualified speech-language pathologists
- Qualified audiologists
- Clinical psychologists
- Registered dietician or nutrition professionals

The new clinician types listed above will be able to participate in MIPS and may report QCDR measures should they choose to report via a QCDR.

<u>Reporting/Data Completeness</u>

- Quality measures are reported over a 12-month reporting period.
- QCDRs and qualified registries must be up and running by January 1 of the performance period to accept and retain data, to allow clinicians to begin their data collection on January 1 of the performance period.
- MIPS eligible clinicians are required to report 6 measures: at least one outcome measure, or if no outcome measures are available or applicable, they must report another high priority measure in lieu of an outcome measure.
- If a MIPS eligible clinician chooses to report via the QCDR measure collection type, they will be required to meet the reporting requirement of 6 quality measures, otherwise they will receive zero points for each unreported quality measure.
- At least one QCDR measure must be an outcome measure, or if no outcome measures are available or applicable, another high priority measure should be reported.

- Data completeness is met by submitting data on at least 60 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria.

Clinician Opt-In

- CMS finalized an opt-in policy that allows some clinicians, who otherwise would have been excluded under the low-volume threshold, the option to participate in MIPS. Specifically, CMS finalized adding a third element (Number of Covered Professional Services) to the low-volume threshold determination and providing an opt-in policy that offers eligible clinicians who meet or exceed one or two, but not all, elements of the low-volume threshold the ability to participate in MIPS.
- Beginning with the 2021 MIPS payment year, the low-volume threshold that applies to an individual eligible clinician, group, or APM Entity group that, during the MIPS determination period, has allowed charges for covered professional services less than or equal to $90,000, furnishes covered professional services to 200 or fewer Medicare Part B-enrolled individuals, or furnishes 200 or fewer covered professional services to Medicare Part B-enrolled individuals.
- If the clinician decides to opt-in to MIPS, the third party intermediary must be able to transmit that decision to CMS.

Benchmarks

- CMS will establish separate benchmarks for QCDR measures since these measures do not have comparable specifications.
- For the 2019 and 2020 MIPS payment years, MIPS eligible clinicians and groups who report on QCDR measures that do not have an available benchmark but meet data completeness will receive 3 measure achievement points (small practices receive 3 points regardless of whether they meet data completeness).

Self-nomination

- For the 2021 MIPS payment year and future years, existing Qualified Registries and QCDRs that are in good standing may attest that certain aspects of their previous year's approved self-nomination have not changed and will be used for the applicable performance period.
- CMS indicated that becoming a qualified registry does not require the level of measure development expertise that is needed to be a QCDR that develops measures.
- The processes for self-nomination for QCDRS and qualified registries are similar, but QCDRs have the option to submit QCDR measures for the quality performance category.

QCDR Measure Requirements

CMS will apply the following criteria with the 2021 MIPS payment year when considering QCDR measures for possible inclusion in MIPS:

- Measures that are beyond the measure concept phase of development.

- Preference given to measures that are outcome-based rather than clinical process measures.
- Measures that address patient safety and adverse events.
- Measures that identify appropriate use of diagnosis and therapeutics.
- Measures that address the domain for care coordination.
- Measures that address the domain for patient and caregiver experience.
- Measures that address efficiency, cost and resource use.
- Measures that address significant variation in performance.

Licensing

- CMS is retaining that QCDR vendors may continue to seek permission from another QCDR to use an existing measure that is owned by the other QCDR.
- Other QCDRs would be required to use the same CMS-assigned QCDR measure ID.

Public Reporting

- For public reporting of QCDR measures, CMS will use the ABC™ methodology and equal ranges method to determine, by measure and collection type, a benchmark and 5-star rating.

2020 Performance Period

- For the 2022 MIPS payment year and future years, the self-nomination period for QCDRs and qualified registries will change to July 1 – September 1 of the CY preceding the applicable performance period (e.g., for the CY 2020 performance period, the self-nomination period will be July 1, 2019 – September 1, 2019).
- A QCDR will be defined as an entity with clinical expertise in medicine and in quality measurement development that collects medical or clinical data on behalf of a MIPS eligible clinician for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.
- The QCDR must have at least 25 participants by January 1 of the year prior to the applicable performance period. These participants do not need to use the QCDR to report MIPS data to CMS; rather, they need to submit data to the QCDR for quality improvement.
    - The policy of requiring 25 participants will also apply to qualified registries.