Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM:

Participating in the Quality Performance Category in the 2019 Performance Year

Updated 7/13/2020
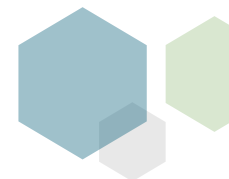
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*CMS is implementing multiple flexibilities to provide relief to clinicians responding to the 2019 Novel Coronavirus (COVID-19) pandemic. Refer to the **Quality Payment Program COVID-19 Response Fact Sheet** for more information.*

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.

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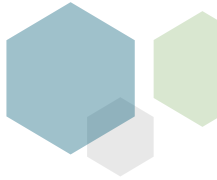
Hyperlinks

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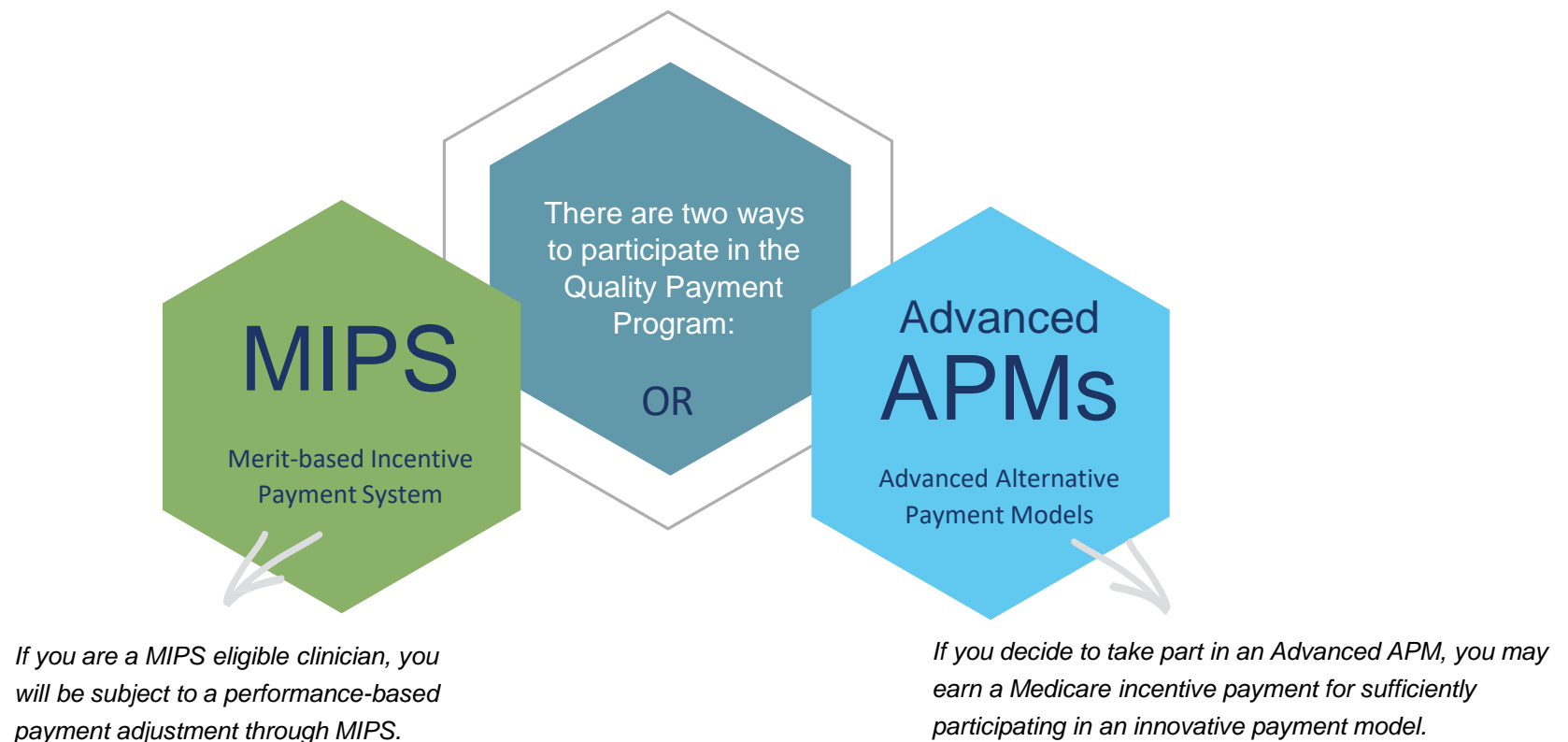
OVERVIEW

Quality Payment
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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 payment rates for clinicians participating in Medicare. By law, MACRA requires CMS to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:

There are two ways to participate in the Quality Payment Program:

OR

MIPS

Merit-based Incentive
Payment System

Advanced
APMs

Advanced Alternative
Payment Models

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

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.
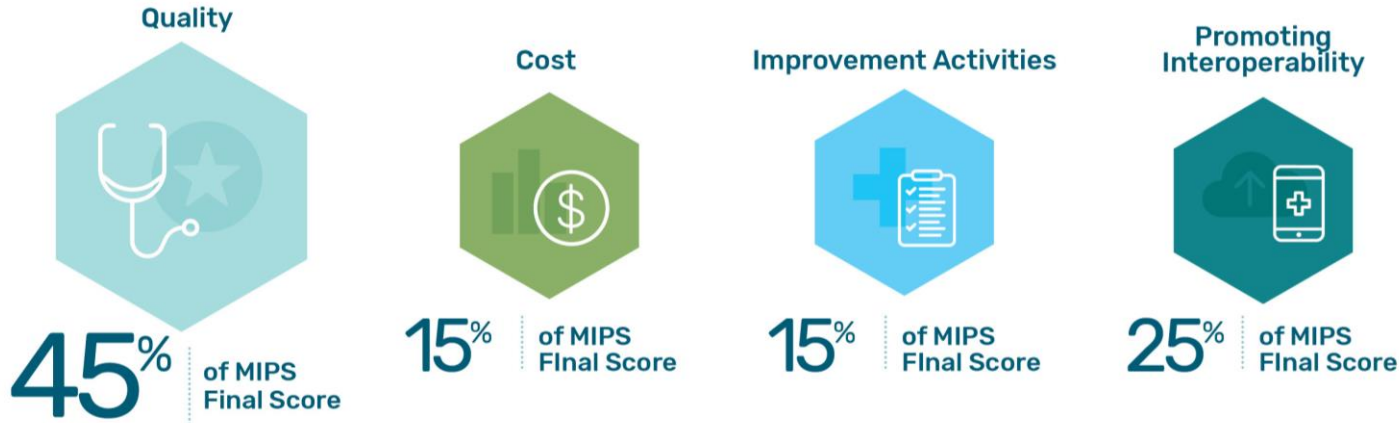
Quality Payment
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What is the Merit-based Incentive Payment System (MIPS)?

There are **4** performance categories under MIPS that affect future Medicare payments. Each performance category has a specific weight, and your performance in these categories contributes to your MIPS final score.

To learn more about how to participate in MIPS:

- *Visit the MIPS Eligibility and Individual or Group Participation web pages on the Quality Payment Program website.*

- *View the 2019 MIPS Participation and Eligibility Fact Sheet.*

- *Check your current participation status using the QPP Participation Status Tool.*

This guide focuses on the **Quality** performance category in 2019 (or "Year 3") of the Quality Payment Program.

QUALITY BASICS

Why Focus on Quality?

Quality measures are tools that help us to:

Measure health care processes, outcomes, and patient experiences of their care

Link outcomes that relate to one or more of these quality goals for health care that's:

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

For the **2019 performance year**, the Quality performance category:

45%

Is worth 45 percent of your MIPS final score

Has a 12-month reporting period (January 1 – December 31, 2019)
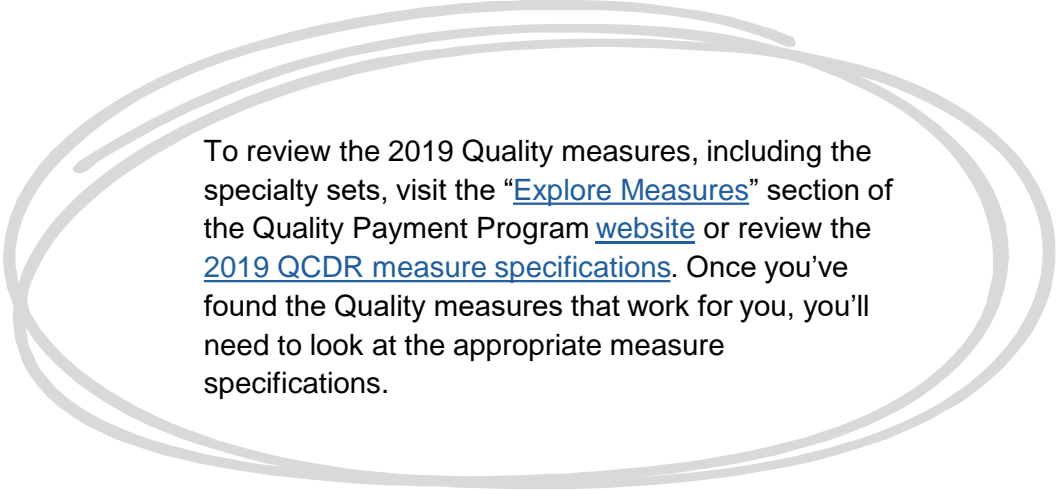
QUALITY MEASURES

Which Quality Measures Can I Choose From?

For the 2019 performance year, you can choose measures most meaningful to your practice from **more than 250 MIPS quality measures**.

You may also:

- Choose MIPS measures from a defined specialty measure set developed by boards or specialty societies

- Select additional Qualified Clinical Data Registry measures (outside of the MIPS quality measures set) if you're working with a QCDR to collect and submit your Quality data

If you're a MIPS APM, you'll have a set of required quality measures that the APM entity will submit for you.

To review the 2019 Quality measures, including the specialty sets, visit the "Explore Measures" section of the Quality Payment Program website or review the 2019 QCDR measure specifications. Once you've found the Quality measures that work for you, you'll need to look at the appropriate measure specifications.

New in 2019: We are implementing an approach to incrementally remove process 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.

- Whether the measure has reached an extremely topped out status, within the 98th to 100th percentile range, due to the extremely high and unvarying performance where meaningful distinctions and improvement in performance can no longer be made.
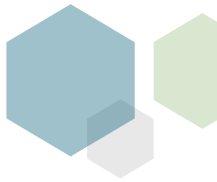
What Quality Measures are Available for the 2019 Performance Year?

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

Quality Measures by Measure Type		
Process Measures	**Outcome Measures**	**Structure Measures**
Process measures show what doctors and other clinicians do to maintain or improve the health of healthy people or those diagnosed with a given condition or disease. These measures usually show generally accepted recommendations for clinical practice. For example: • The percentage of people getting preventive services (such as mammograms or immunizations). Process measures can tell consumers about the medical care they should get for a given condition or disease.	Outcome measures show how a health care service or intervention affects patients' health status. For example: • The percentage of patients who died because of surgery (surgical mortality rates). • The rate of surgical complications or hospital – acquired infections. Outcome measures may seem to be the "gold standard" in measuring quality, but outcomes happen for many reasons, some of which clinicians don't have control over.	Structure measures give consumers a sense of a health care provider's capacity, systems, and processes to provide high-quality care. For 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.
Patient Engagement and Patient Experience Measures	**Intermediate Outcome Measures**	**Efficiency Measures**
Patient engagement and patient experience measures use direct feedback from patients and their caregivers about the experience of receiving care. The information is usually collected through surveys. For 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. For example: • Reducing blood pressure in the short-term decreases the risk of longer-term outcomes such as cardiac infarction or stroke.	Efficiency measures can be used to assess the variability of the cost of healthcare and to direct efforts to make healthcare more affordable. For 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).

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What Quality Measures are Available for the 2019 Performance Year? *(continued)*

Quality Measures by Measure Type
Patient Reported Outcome Measures

These measures are derived from outcomes reported by patients and can include any report of a patient's health condition, health behavior, or experience with health care that comes directly from the patient without interpretation of the patient's response by a clinician. These are related to health-related quality of life, symptoms and symptom burden, etc.

For example:
- The average change in back pain following a Lumbar discectomy or Laminotomy is measured based on the patient's reported level of their back pain.

High Priority Measures

MIPS scoring policies emphasize and focus on high priority measures that impact beneficiaries. High priority measures are measures that fall within these measure categories:

- Outcome (includes intermediate-outcome and patient-reported outcome measures)

- Appropriate use

- Patient experience

- Patient safety

- Efficiency measures

- Care coordination

- **Opioid-related quality measures**

New for 2019: We revised the definition of a high priority measure to include opioid-related quality measures.

High-priority measures are not an additional measure type. All 7 quality measure types (efficiency, intermediate outcome, outcome, patient-reported outcome, patient engagement experience, process and structure) include high priority measures.

TIP: If you're in a MIPS APM, you'll have a set of required quality measures that the APM Entity will submit for you. For more information, go to: https://qpp.cms.gov/apms/mips-apms

REPORTING REQUIREMENTS

What Data Do I Need to Submit?

To participate fully in the Quality performance category, you need to submit collected data for **at least 6 quality measures** (for the 12-month reporting period), **including at least 1 outcome measure**. If no outcome measures are applicable, you may report another high-priority measure.

Submit at Least
6 Quality
Measures

or

Submit a Specialty
Measure Set

The CAHPS for MIPS Survey measure can count for 1 of the 6 measures (patient experience measure or 1 high priority measure).

You may also select a specialty-specific set of measures (e.g., cardiology, dentistry, emergency medicine, general surgery). Submitting a complete specialty set counts as full participation, even when the specialty set contains fewer than 6 measures.

EXCEPTION: If you're registered for and choose to submit data using the CMS Web Interface, you must **report all 10 required Web Interface measures for the full year** (January 1 – December 31, 2019).
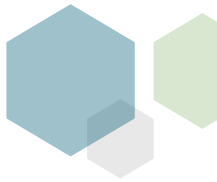
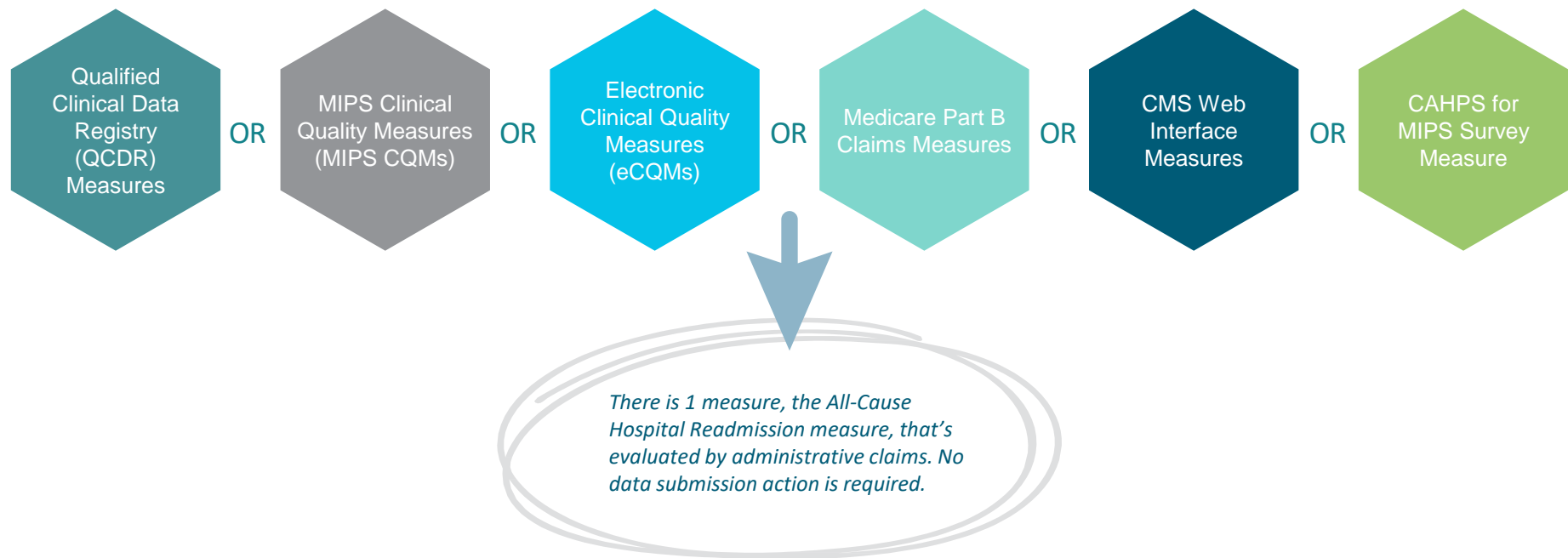TIP: To review the 2019 Quality measures, including the specialty sets, visit the "Explore Measures" section of the Quality Payment Program website.

COLLECTION TYPES

How Can I Collect Quality Data?

There are 6 ways you can collect and submit your Quality performance category data:

Qualified Clinical Data Registry (QCDR) Measures

OR

MIPS Clinical Quality Measures (MIPS CQMs)

OR

Electronic Clinical Quality Measures (eCQMs)

OR

Medicare Part B Claims Measures

OR

CMS Web Interface Measures

OR

CAHPS for MIPS Survey Measure

There is 1 measure, the All-Cause Hospital Readmission measure, that's evaluated by administrative claims. No data submission action is required.

Starting in the 2019 performance year, we will aggregate quality measures collected through multiple collection types. If you submit the same measure collected via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring. However, CMS Web Interface measures cannot be scored with other collection types other than the CMS approved survey vendor measure for CAHPS for MIPS and/or administrative claims measures.

Collection Types

The table below provides additional details on each collection type, including which types are available to those submitting as an individual vs. group/virtual group.

Qualified Clinical Data Registry (QCDR) Measures

MIPS Clinical Quality Measures (MIPS CQMs)

Electronic Clinical Quality Measures (eCQMs)

Medicare Part B Claims Measures

Collection Type	How it Works
Qualified Clinical Data Registry (QCDR) Measures • Individuals • Groups • Virtual Groups	• CMS-approved QCDRs collect medical and/or clinical data to track patients and disease. • Each QCDR usually gives customized instructions about how to submit data. • For MIPS, eligible clinicians who choose this option have to participate with a QCDR that we've approved for 2019.
MIPS Clinical Quality Measures (MIPS CQMs) (formerly referred to as "registry measures") • Individuals • Groups • Virtual Groups	• MIPS CQMs are collected by Qualified Registries and QCDRs and are submitted (via the Direct or Log-in and Upload submission types) on behalf of MIPS eligible clinicians. • Eligible clinicians who choose this collection type will have to participate with a Qualified Registry or QCDR that we've approved.
Electronic Clinical Quality Measures (eCQMs) • Individuals • Groups • Virtual Groups	• Clinicians collect data through their certified EHR technology (CEHRT). • Groups and virtual groups that collect data using multiple EHR systems will need to aggregate their data before it's submitted. • IMPORTANT: If you submit eCQMs, you'll need to collect your data in certified EHR technology. You must have 2015 Edition CEHRT in place by December 31, 2019, and the 2015 CEHRT must be used to generate your eCQM data for reporting.
Medicare Part B Claims Measures • Individuals • Groups • Virtual Groups *Please note this collection type is only available to MIPS eligible clinicians in small practices*	• Clinicians in small practices pick measures and report through their routine billing processes. • Clinicians will need to add certain billing codes to claims filed for denominator eligible patient encounters to show that the required quality action occurred or that the denominator exclusion was met. • For the 2019 performance year, Medicare Part B claims must be submitted and processed no later than 60 days following the close of the performance year to be analyzed for the Quality performance category.

Collection Types

Collection Type	How It Works
Administrative Claims Measure • Groups • Virtual Groups *No data submission required*	• Includes 1 measure, the All-Cause Hospital Readmission measure, that's evaluated by administrative claims. • Groups and virtual groups with 16 or more clinicians are automatically subject to this measure if they meet the case minimum of 200 patients. • If the group or virtual group falls below the case minimum, the measure won't be calculated, and clinicians will only be scored on the reported measures
CMS Web Interface Measures • Groups • Virtual Groups	• Secure internet-based application that pre-registered groups and virtual groups with 25 or more clinicians can use. • A sample of beneficiaries are identified for reporting and we partially pre-populate the CMS Web Interface with claims data from the group's Medicare Part A and Part B beneficiaries who've been assigned to the group. Then, the group adds the rest of the clinical data for the pre-populated Medicare patients.

CAHPS for MIPS Survey Measure
• Groups
• Virtual Groups
	• Groups that choose to report their patient experience data via the CAHPS for MIPS survey must:
	  - Pick another collection type and submission type to collect and submit their remaining quality measures.
	  - Meet minimum sample sizes to administer the CAHPS for MIPS survey.
	• New in 2019: A group that wishes to voluntarily elect to participate in the CAHPS for MIPS survey measure must use a survey vendor that is approved by CMS for the applicable performance year to transmit survey measure data to us.

Administrative Claims Measure

CMS Web Interface Measures

CAHPS for MIPS Survey Measure

SUBMITTING QUALITY DATA

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How and When Do I Submit Data?

We'll assess your performance on the Quality data you submit.

For the Medicare Part B claims submission type, which **only** small practices can use, we receive quality data when claims are submitted for payment. Please note that your Medicare Part B claims measures for the 2019 performance year must be processed by your Medicare Administrative Contractor (MAC) no later than 60 days following the close of the performance year to be analyzed.

QPP Account

SIGN IN   REGISTER

Sign in to QPP

USER ID

User ID

PASSWORD

Password

Show password

Forgot your user id or password? Recover ID or reset password

TIP: You can review your performance feedback for quality data submitted via claims by logging into https://qpp.cms.gov/login. The feedback will be updated on a monthly basis.

For the Direct, Log-in and Upload, and CMS Web Interface submission types, the data submission period will begin on **January 2, 2020, and will end March 31, 2020**.

What Data Submission Types Can I Use?

The following chart outlines the submission types that include QCDRs and Qualified Registries and how they work.

Submission Type	Description
Direct	Authorized third-party intermediaries (such as QCDRs and Qualified Registries) can perform a direct submission, transmitting data through a computer-to-computer interaction, such as an API.
Log-in and Upload	Individual clinicians, groups, virtual groups, and third-party intermediaries can login and upload quality measure data in an approved file format on qpp.cms.gov.
Log-in and Attest	The log-in and attest submission type is not an option for submitting Quality performance category data.
Medicare Part B Claims	Individuals, groups, and virtual groups that are small practices can submit their quality measures via Medicare Part B Claims throughout the performance year.
CMS Web Interface	Registered groups and virtual groups, with 25 or more clinicians, can submit their quality measures through the CMS Web Interface.

SCORING

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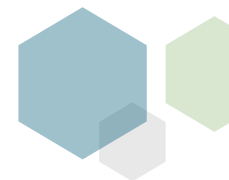
How Many Points Will I Receive for Each Measure I Submit?

Quality measures submitted for the 2019 performance year will receive **between 1 and 10 measure** achievement points.

You'll receive:

Between
3 and **10**
achievement
points

OR

3
achievement
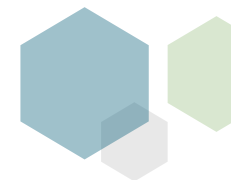points

OR

1
achievement point

based on your performance if the quality measure meets the data completeness criterion (60% for 2019), has a benchmark, and the volume of cases is sufficient (> 20 cases for most measures)

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)*

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.

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Which Quality Measures are Topped Out in 2019?

The following are examples of topped out measures that have been capped at 7 points each for 2019:

- Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality measure ID: 21)

- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality measure ID: 23)

- Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality measure ID: 262)

- Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy. (Quality measure ID: 52)

To identify if a measure is topped out, see the 2019 Quality Measure Benchmarks.

New in 2019: *Extremely Topped-Out Measures.* A measure is extremely topped out when the average mean performance is within the 98th to 100th percentile range. To identify if a measure is extremely topped out, see the 2019 Quality Measure Benchmarks.

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 self-nomination process, it may not be approved for the applicable performance year.
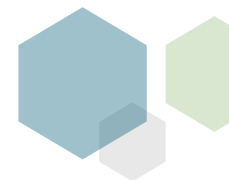
How are the Benchmarks Established?
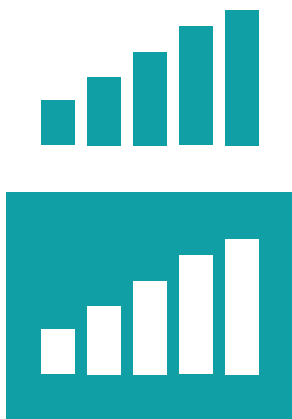
The 2019 Quality Measure Benchmarks for the MIPS CQMs, QCDR Measures, Medicare Part B claims measures, and eCQMs collection types are established using 2017 MIPS performance data, 2 years before the performance year.
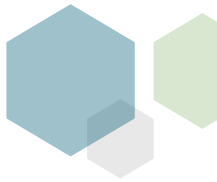
The CAHPS for MIPS benchmarks for performance year 2019 have not been established yet because a revised survey was used for performance year 2018 and therefore sufficient historical data are not available. However, benchmarks for performance year 2019 will be calculated in the Spring of 2020 using performance year data for each summary survey measure (SSM).

For the CMS Web Interface quality measures, benchmarks are the same as those used for the Medicare Shared Savings Program.

How are the Benchmarks Converted to Achievement Points?

- When you submit measures for MIPS, each one is assessed against a benchmark to determine how many achievement points the measure earns.
- We establish Quality performance benchmarks either:
  - Prior to the reporting period for which they apply (*historical benchmarks* created from data submitted 2 years prior)
  - From data submitted for that performance year (performance year benchmarks for the 2019 period will be calculated from 2019 data submitted during the data submission period)

# How are the Benchmarks Converted to Achievement Points? *(continued)*

- Each quality measure is scored using a 10-point scoring system, except for:

  - The topped-out MIPS quality measures finalized with a 7-point scale,

  - Measures that don't meet data completeness criteria, and

  - Measures that either don't have a benchmark and/or 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 level.

- For measures with inverse performance rates, such as Measure #1 Diabetes: Hemoglobin A1c Poor Control where a lower performance rate indicates better performance, decile 10 starts with the lowest performance rate and decile 1 has the highest performance rate.

What if a measure I chose 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 year data.*

- *If the measure does not also meet data completeness, it will receive 1 point (except for small practices, which would receive 3 measure achievement points).*

- *This applies to measures across all collection types except for CMS Web Interface measures and administrative claims measures.*

NOTE: There is a 3-point floor for measures that can be reliably scored based on performance for the 2019 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.)
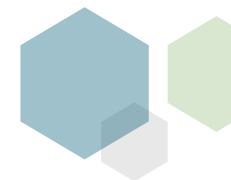
How Does CMS Calculate My Quality Performance Category Score?

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

Quality Performance Category Percent Score
(Not to exceed 100%)

$=$

Total Measure Achievement Points $+$ Measure Bonus Points

Total Available Measure Achievement Points*

* Based on collection type.

Maximum Points by Reporting Level

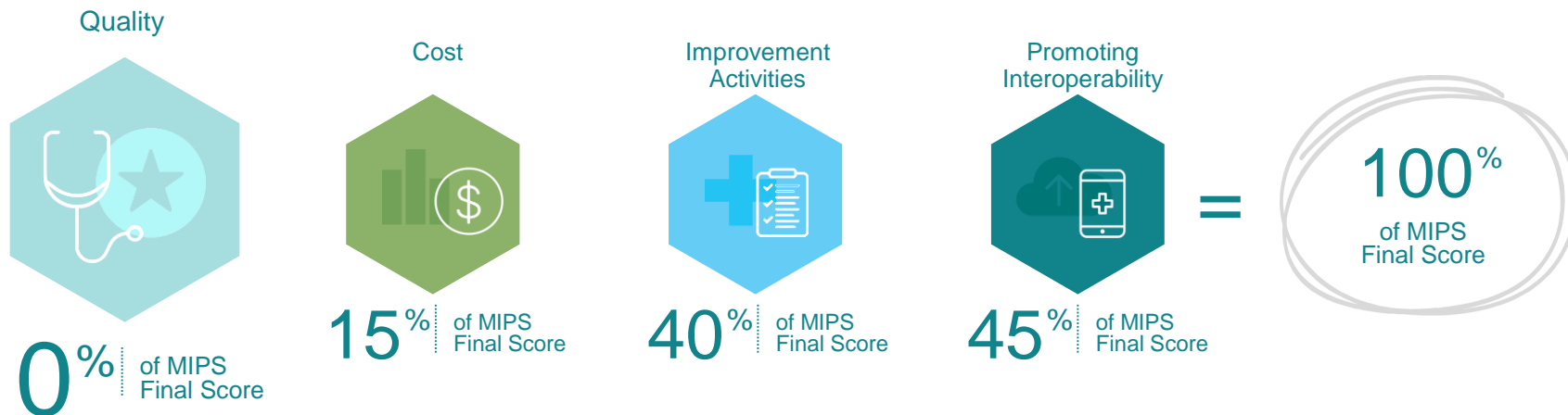| Individuals	Groups/Virtual Groups				
60 POINTS	**60 POINTS**	**70 POINTS**	**50 POINTS**	**60 POINTS**	**70 POINTS**
	If the readmission measure does not apply	For 6 measures + 1 readmission measure	for CMS Web Interface measures	for CMS Web Interface measures + 1 readmission measure OR CAHPS for MIPS Survey	for CMS Web Interface measures + 1 readmission measure AND CAHPS for MIPS Survey

How is the Quality Performance Category Reweighted and When Would This Apply to Me?

If you don't submit data for the Quality performance category because there are no Quality measures available to you, you won't earn any points in this category, and the Improvement Activities and Promoting Interoperability performance categories would be reweighted.

Quality

Cost

Improvement Activities

Promoting Interoperability

0% of MIPS Final Score

15% of MIPS Final Score

40% of MIPS Final Score

45% of MIPS Final Score

= 100% of MIPS Final Score

NOTE: We anticipate that reweighting of the Quality performance category would be a rare occurrence because there are quality measures applicable and available for most clinicians. Please contact the Quality Payment Program if you believe there are no quality measures available to you.

What is the End-to-End Electronic Reporting Bonus?

- **1 bonus point** per measure for reporting your quality data directly from your CEHRT without any manual manipulation. (Your EHR must be certified to the 2015 Edition by the last day of the performance year.)

- It is available to measures reported through the direct, Log-in and Upload, and CMS Web Interface submission types.

- These are capped at **10%** of your Quality performance category denominator.

What is the Bonus for Submitting Additional Measures Beyond the Required Outcome/High Priority Measures?

You'll receive:

- **1 bonus point** for each additional high priority measure

- **2 bonus points** for each additional outcome and patient experience measure

New for 2019: The definition of a high priority measure now includes opioid-related measures.

Beginning with the 2019 performance period, the high priority measure bonus will **not** be applied to groups and virtual groups for measures submitted via the CMS Web Interface. However, the high priority measure bonus is still available to clinicians participating in an ACO and scored under the APM Scoring Standard for the 2019 performance period; the high priority measure bonus will be discontinued for ACO participants starting with the 2020 performance period.

Bonus points are added to the Quality performance category achievement points (those earned based on performance) and are capped at 10% of the Quality performance category denominator. This is separate from the 10% cap on the end-to-end reporting bonus, and these can be earned in addition to the bonus points available for end-to-end electronic reporting.

How is the Small Practice Bonus Applied in 2019?

The small practice bonus will now be added to the Quality performance category, rather than in the MIPS final score calculation. Beginning in Year 3 (2019), 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.

Note for 2019: 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 year (December 31, 2019). Therefore, in order for practices to earn the end-to-end bonus for reporting eCQMs for the 2019 performance year, they will need to report the latest version of the eCQM extracted from 2015 Edition CEHRT.

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How Do We Evaluate Eligibility for Improvement Scoring?

You'll be evaluated for improvement scoring in 2019 when you:

Participate fully in the Quality performance category for the current performance year (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 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 year (Year 2, 2018)

AND

Submit data under the same identifier for the 2 performance years, or if we can compare the data submitted for the 2 performance years.

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How is Improvement Scoring Calculated and How Will It Affect My Performance Category Score?

For the 2019 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.

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.


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

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

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

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

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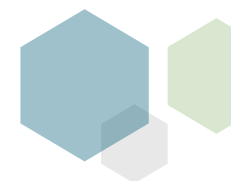
How Does the Small Practice Bonus Affect My Score?

The small practice bonus has been moved from a bonus added to the MIPS final score to a Quality performance category score bonus for 2019. The Quality performance category percent score equation for small practices is a product of the following equation:

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

How Does Facility-based Measurement Affect My Quality Performance Category Score?

Beginning with the 2019 performance year, we will identify clinicians and groups eligible for facility-based scoring. These clinicians and 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 attributed to a facility with a Hospital Value-Based Purchasing (VBP) Program score for the 2019 performance year	AND	The Hospital VBP score results in a higher score than MIPS Quality measure data you submit and MIPS Cost measure data we calculate for you.

To learn more, see the 2019 Facility-based Measurement Fact Sheet.
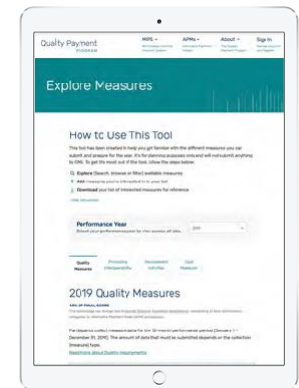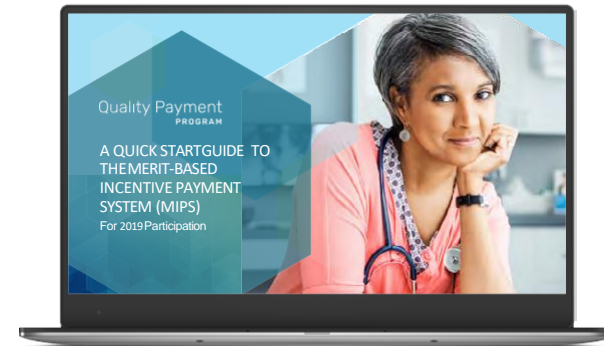
RESOURCES, GLOSSARY, AND VERSION HISTORY

Resources, Glossary, and Version History

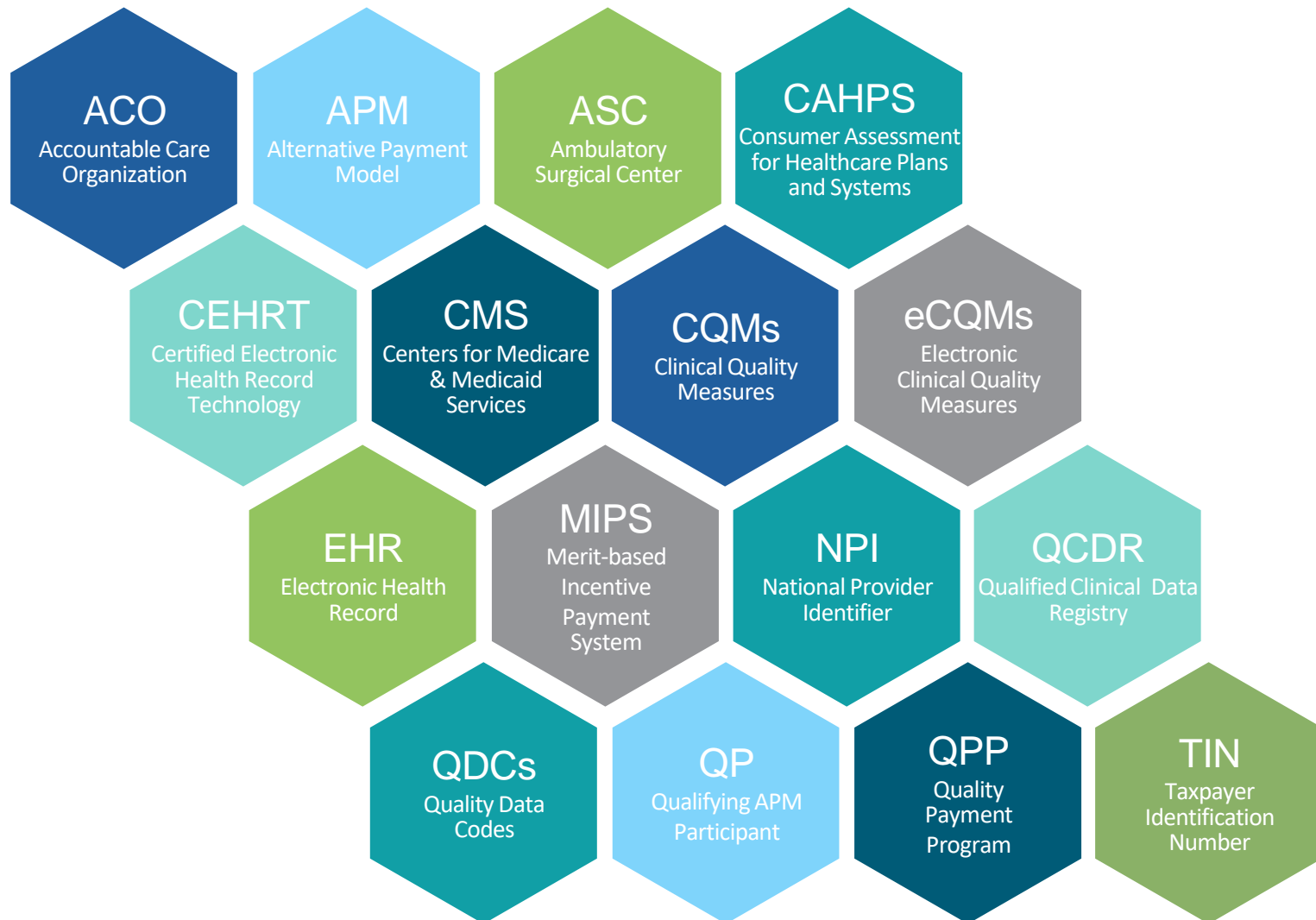## Additional Resources

The following resources are available on the QPP Resource Library:

- 2019 MIPS Quick Start Guide
- 2019 MIPS Quality Performance Category Fact Sheet
- 2019 MIPS Participation and Eligibility Fact Sheet
- 2019 Quality Measure Benchmarks
- 2019 Cross-Cutting Quality Measures
- 2019 Qualified Clinical Data Registries (QCDRs) Qualified Posting
- 2019 Qualified Registries Qualified Posting
- 2019 QPP Final Rule—Updates for QCDRs and Registries
- 2019 Self-Nomination Toolkit for QCDRs & Registries
- 2019 CMS Web Interface Measure Specifications and Supporting Documents
- 2019 Clinical Quality Measure Specifications and Supporting Documents
- 2019 Medicare Part B Claims Measure Specifications and Supporting Documents
- 2019 CMS Web Interface Fact Sheet
- 2019 CMS Web Interface User Guide
- 2019 CAHPS for MIPS Overview Fact Sheet
- 2019 MIPS Scoring Guide

Resources, Glossary, and Version History
Glossary

Quality Payment PROGRAM

ACO Accountable Care Organization

APM Alternative Payment Model

ASC Ambulatory Surgical Center

CAHPS Consumer Assessment for Healthcare Plans and Systems

CEHRT Certified Electronic Health Record Technology

CMS Centers for Medicare & Medicaid Services

CQMs Clinical Quality Measures

eCQMs Electronic Clinical Quality Measures

EHR Electronic Health Record

MIPS Merit-based Incentive Payment System

NPI National Provider Identifier

QCDR Qualified Clinical Data Registry

QDCs Quality Data Codes

QP Qualifying APM Participant

QPP Quality Payment Program

TIN Taxpayer Identification Number

Quality Payment
PROGRAM

Version History

Date	Description
7/13/2020	On page 28, updated the graphic to reflect revised maximum points available for CMS Web Interface measures now that 5 of the 10 measures are classified as pay-for-reporting in the Medicare Shared Savings Program.
4/27/2020	Added disclaimer language regarding changes to 2019 MIPS in response to COVID-19.
2/20/2020	• On page 28, updated the graphic to reflect revised maximum points available for CMS Web Interface measures now that 4 of the 10 measures are classified as pay-for-reporting in the Medicare Shared Savings Program. • On page 30, clarified the high priority measure bonus applicability to ACOs for the 2019 performance period.
6/4/2019	Original posting