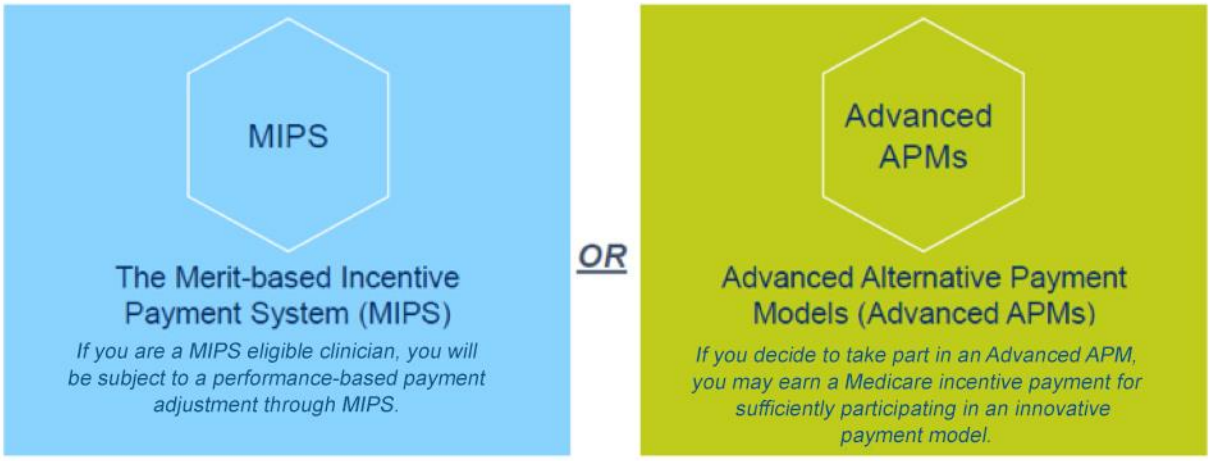
Quality Payment
PROGRAM

2018 MIPS Quality Performance Category Fact Sheet

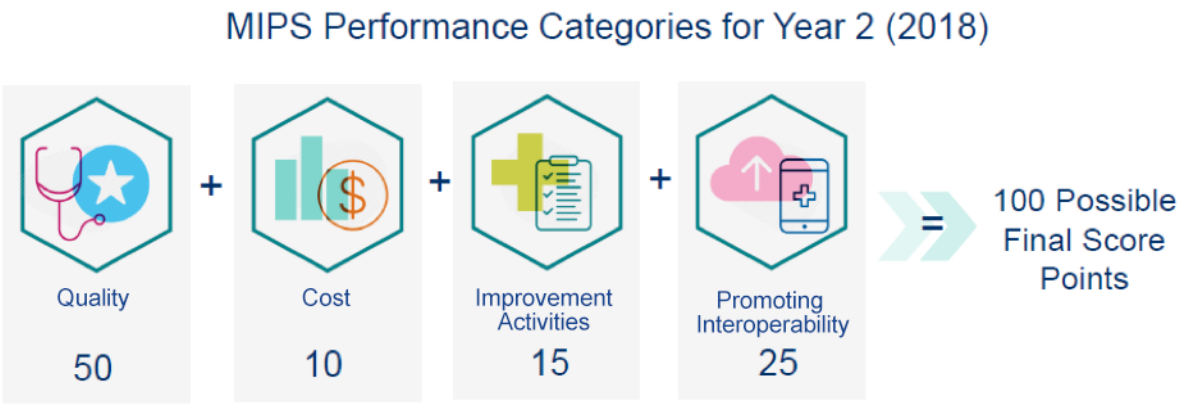
For Individual MIPS Eligible Clinicians, Groups, and Virtual Groups

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. MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:



Under MIPS, for clinicians who are not APM participants, there are 4 performance categories that affect your future Medicare payments. Each performance category is scored by itself and has a specific weight that is part of the MIPS Final Score. The payment adjustment assessed for MIPS eligible clinicians is based on the Final Score. These are the performance category weights for the 2018 performance period:



For APM participants, the 2018 Quality Performance Category Scoring for Alternative Payment Models, provides guidance specific to your APM.

Beginning in 2018, MIPS eligible clinicians, who are not APM participants, may participate in MIPS individually, as a group, or as a virtual group.

Participate as an individual	**Participate as a group**	**Participate as a virtual group**
MIPS eligible clinicians participating as individuals will have their **payment adjustment based on their individual performance.** An individual is a single clinician, identified by a single National Provider Identifier (NPI) number tied to a Taxpayer Identification Number (TIN).	MIPS eligible clinicians participating in a MIPS group will receive a **payment adjustment based on the group's performance**. Under MIPS, a group is a single Taxpayer Identification Number (TIN) with 2 or more MIPS eligible clinicians, as identified by their National Provider Identifiers (NPI), who have reassigned their Medicare billing rights to the TIN.	MIPS eligible clinicians participating in a MIPS virtual group will receive a **payment adjustment based on the virtual group's performance**. A virtual group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year.

Please note that some clinicians participate in MIPS through a MIPS APM, which has separate requirements and scoring standards, and may receive a payment adjustment based on those standards. A comprehensive list of APMs is available as well as an array of resources in the Quality Payment Program resource library. Additionally, if you are a part of a MIPS APM, we encourage you to work with your APM on program requirements.

Why Focus on Quality?

Quality measures are tools that help us measure health care processes, outcomes, and patient experiences of their care. Quality measures also help us link outcomes that relate to 1 or more of these quality goals for health care that's:

- Effective,
- Safe,
- Efficient,
- Patient-centered,
- Equitable, and
- Timely

There are more than 270 MIPS quality measures available for reporting for the 2018 performance period in the Quality Payment Program.

If you're a MIPS eligible clinician reporting through a Qualified Clinical Data Registry (QCDR), you can report on approved QCDR measures developed by the QCDRs (outside of the MIPS quality measure set finalized in the rule). These measures are a mix of process measures, outcome measures, and high priority measures.

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

Quality Measures by Measure Type		
Process 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:	**Outcome measures** 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.	**Structure measures** Structural 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

• 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 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.	system for mammogram screenings. • Checking for the availability of diagnostics for patient follow up and comparisons.
Patient Engagement and Patient Experience 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** 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** 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).
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 • Appropriate use • Patient experience • Patient safety • Efficiency measures • Care coordination		

All 6 quality measure types (efficiency, intermediate outcome, outcome, patient engagement experience, process and structure) include high priority measures.

What Do I Have to Do for Quality Performance in Year 2 (2018)?

Starting in 2018, there is a 12-month Quality performance period (January 1 – December 31, 2018). When you report a full year of quality data, we get a more complete picture of your performance and you have a greater chance to earn a higher positive payment adjustment.

You will also have the chance to raise your 2018 Quality category score based on your rate of improvement from your Quality category score in the transition year.

To meet the Quality performance category requirements for most data submission mechanisms, a clinician, group, or virtual group has to report the following:

- Six quality measures (or a complete specialty measure set) for the 12-month performance period.
- The six measures must include at least 1 outcome measure or another high priority measure in the absence of an applicable outcome measure.

Ways to Submit Quality Data

We urge eligible clinicians, groups, and virtual groups to review each data submission mechanism carefully and choose what works best for them. Be aware that many options use third party intermediaries.

Similar to the transition year, CMS will not aggregate quality measures submitted through multiple submission mechanisms for the 2018 performance period, with the exception of the CAHPS for MIPS survey reported by registered groups or virtual groups.

Data submission mechanism	How does it work?
Qualified Clinical Data Registry (QCDR) Can be used by individual MIPS eligible clinicians, groups, and 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. You can find approved QCDRs in the 2018 QCDR Qualified Posting document in the Quality Payment Program resource library. You can also find a list of the 2018 QCDR Measure Specifications in the Quality Payment Program resource library.

Data submission mechanism	How does it work?
Qualified Registry Can be used by individual MIPS eligible clinicians, groups, and virtual groups.	A Qualified Registry collects clinical data and submits it to us for MIPS eligible clinicians. For MIPS, eligible clinicians who choose this option have to participate with a Qualified Registry that we've approved. You can find approved Qualified Registries in the 2018 Qualified Registries Qualified Posting document in the Quality Payment Program resource library.
Electronic Health Record (EHR) Can be used by individual MIPS eligible clinicians, groups, and virtual groups.	Clinicians submit data to us they've collected through their certified EHR technology (CEHRT). Clinicians can do this themselves or by working with a qualified health IT vendor who will submit the data for them. Groups and virtual groups that collect data using multiple EHR systems will need to aggregate their data before it's submitted.
Claims Can only be used by individual MIPS eligible clinicians.	Clinicians pick measures and report through their routine billing processes. If they choose this option, they'll need to add certain billing codes to denominator eligible claims to show that the required quality action or exclusion happened. For the 2018 performance period, claims must be submitted and processed no later than 60 days following the close of the performance period to be analyzed for the Quality performance category. Please refer to the 2018 Claims Submission Fact Sheet for additional information. .
CMS Web Interface Can only be used by groups and virtual groups with 25 or more clinicians and Medicare Shared Savings Program (SSP) ACOs reporting on behalf of MIPS eligible clinicians.	This is a 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. Reporting via the Web Interface requires that you submit data for all measures in the application. In the event that there isn't a sufficient sample size, CMS will recommend selecting a different data submission option.

Data submission mechanism	How does it work?
	Groups and virtual groups interested in reporting through the CMS Web Interface need to register at qpp.cms.gov between **April 1, 2018 and June 30, 2018**. ACOs participating in the Medicare Shared Savings Program (Shared Savings Program) do not need to register for CMS Web Interface quality reporting because it is a requirement of the Shared Savings Program.
CAHPS for MIPS Survey Vendors Can only be used by groups and virtual groups.	Groups and Virtual Groups interested in administering the CAHPS for MIPS survey need to register via qpp.cms.gov between April 1, 2018 and June 30, 2018. Groups that choose to report their patient experience data via the CAHPS for MIPS survey have to pick another data submission mechanism to submit their remaining quality measures. Groups must meet minimum sample sizes to administer the CAHPS for MIPS survey. We'll let groups know if they meet minimum sample sizes after group registration closes and assignment sampling finishes. The CAHPS for MIPS survey isn't for groups that don't give primary care services (for example, a group of surgeons). Groups are responsible for the costs that go with survey administration and have to contract with a CMS-approved survey vendor to conduct the survey. A list of approved vendors will be posted on the Quality Payment Program resource library. The conditional list of 2018 CMS-Approved CAHPS for MIPS survey vendors will be made publicly available.
The Quality performance category has 1 measure, the All-Cause Hospital Readmission measure, that's evaluated by administrative claims. Groups and virtual groups with 16 or more clinicians are subject to the All-Cause Hospital Readmission measure if they meet the case minimum of 200 patients for the measure. If the group or virtual group falls below the case minimum, the All-Cause Hospital Readmission measure won't be calculated and clinicians will only be scored on the reported measures. Please note that no data submission action is required for administrative claims evaluation and that the All-Cause Hospital Readmission measure is not a part of the APM Scoring Standard and won't be calculated for groups participating in a Shared Savings Program ACO.	

Getting Started

Here are 5 steps to help you get started:

1. See if you're a MIPS eligible clinician

You're a MIPS eligible clinician or group if you're 1 of the following clinician types who bills more than $90,000 in Medicare Part B allowed charges for covered professional services **and** furnish covered professional services to more than 200 Part B-enrolled Medicare beneficiaries:

- Physicians, which includes doctors of medicine, doctors of osteopathy (including osteopathic practitioners), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Clinical nurse specialists
- Certified registered nurse anesthetists
- In any clinician group that includes 1 of the professionals listed above

You can use the Participation Status Look-up tool on qpp.cms.gov, which was updated with 2018 eligibility information in the second quarter of 2018.

2. Choose your measures

There are more than 270 quality measures in MIPS; additionally, if you chose to work with a QCDR, additional QCDR measures may be available for your choosing. You can start looking at the measures to find what works best for you, your group, or virtual group. If you're a group, virtual group, or MIPS APM reporting via the CMS Web Interface, you are required to report on the measures in the application.

To meet Quality performance category requirements, you need to pick at least 6 quality measures, including at least 1 outcome measure or a high priority measure or report on a complete quality measure specialty or sub-specialty set.

3. Understand your quality measures

Once you've found the measures that work for you, you'll need to look at the appropriate measure specifications that are aligned with them. Measure specifications describe each measure and outline their elements.

Each submission mechanism has its own measure specifications, which can be found in the Quality Payment Program resource library.

4. Collect your data

You should start data collection on **January 1, 2018** to meet data completeness requirements and make it more likely to earn a higher positive payment adjustment**.** For the Quality

Performance Category, you'll need to report on 12 months of quality data for the 2018 performance period (January 1, 2018 – December 31, 2018).

If you're participating in a MIPS APM, you should work with your APM entity on timelines and required activities for the 2018 performance period.

5. **Submit your 2018 data**

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

For the claims submission mechanism, which only individual Eligible Clinicians can use, we receive quality data when claims are submitted for payment. Please note that your claims for the 2018 performance period must be processed and available in the national claims data warehouse no later than 60 days following the close of the performance period to be analyzed.

For QCDRs, Qualified Registries, EHR, and the CMS Web Interface, the data submission period will begin on January 2, 2019, and will end no later than March 31, 2019**.**

You'll be able to find a submission timeline, that includes due dates, on qpp.cms.gov. You can also review your performance feedback on quality data submitted via claims by logging into the QPP website. This feedback will be updated on a monthly basis.

What is Quality Scoring?

For the 2018 performance period:

- The weight of the Quality performance category is 50% of your MIPS final score.
- Quality measures that can be scored against a benchmark will receive between 3 and 10 points as measure achievement points.
    - Exception: There are specified topped-out measures that are capped at 7 points each for 2018. They are:
        - Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality Measure ID: 21)
        - Melanoma: Overutilization of Imaging Studies in Melanoma. (Quality Measure ID: 224)
        - 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)

        - Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description. (Quality measure ID: 359)[1]
        - Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy. (Quality Measure ID: 52)
- Quality measures that don't have a benchmark or do not meet the case minimum (e.g., a denominator of 20) will receive 3 points.
- Quality measures that don't meet data completeness requirements (60% for 2018) will receive 1 point instead of 3 points. There is one exception in which small practices, consisting of 15 or fewer eligible clinicians, would receive 3 points. Each submission mechanism requires a minimum amount of data to meet data completeness requirement:
    - QCDR, qualified registry, and EHR submission mechanisms require at least 60% of all-payer patients or visits qualifying for the denominator of each measure to be reported.
    - Claims reporting requires at least 60% of Medicare patients or visits.
    - The CMS Web Interface data submission mechanism requires at least 248 Medicare patients randomly selected by CMS to be reported upon for each measure.
- You can earn bonus points based on improvement at the Quality performance category level from 1 year to the next.

National Benchmarks

What are benchmarks?

Quality benchmarks for the Qualified Registry/QCDR, claims, and EHR submission mechanisms are established using historical data that's collected 2 years before the performance period. The 2018 Quality benchmarks were established using performance data submitted to the Physician Quality Reporting System (PQRS) collected in 2016.

For 2017 CAHPS for MIPS, the benchmarks were based on 2 sets of surveys: 2015 CAHPS for PQRS and CAHPS for Accountable Care Organizations (ACOs). However, the 2018 CAHPS for MIPS benchmarks haven't been established yet since we're using a revised survey but will be available for each summary survey measure (SSM). This means we'll calculate benchmarks based on 2018 performance data.

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

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[1] Please note there was not enough data to create a historical benchmark for this measure. If a performance period benchmark can be created and the measure remains topped out, this measure will be capped at 7 points.

How do benchmarks convert to points?

When you submit measures for the MIPS Quality performance category, each measure is assessed against its submission mechanism-specific benchmark to see how many points are earned based on your quality performance. Each quality measure is converted into a 10-point scoring system, except for the topped-out measures finalized with a 7-point scale.

Performance on quality measures is broken down into “deciles,” with each decile having a value between 3 and 10 points. The deciles will be based on stratified levels of national performance (benchmarks) within that baseline period. We’ll 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 3 starts with the highest performance rate and decile 10 has the lowest performance rate.

If a measure can be reliably scored against a benchmark, then you can earn 3-10 points, except for the topped-out measures finalized with a 7-point scale.

Reliably scored means that:

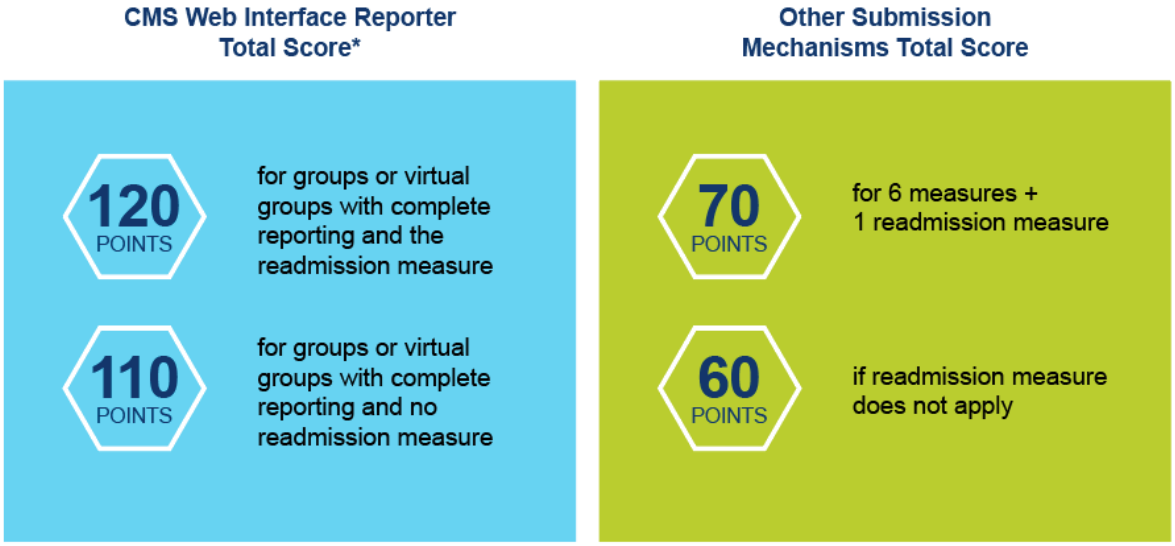
- A national benchmark exists.
- The sufficient case volume has been met (>20 cases for most measures; >200 cases for readmissions).

The data completeness criteria has been met (meaning at least 60% of possible data is submitted).

What if a measure I chose doesn’t have a national benchmark?

Quality measures that can’t be reliably scored against a benchmark, or quality measures without a benchmark, will receive 3 points unless a benchmark can be established with performance period data.

Maximum Number of Points by Submission Mechanism



There are 130 available points if you submit your data via the CMS Web Interface and administer the CAHPS for MIPS survey.

There is a validation process for quality measures that are collected through claims and/or qualified registries if you didn't have 6 applicable quality measures.

How do we determine applicable quality measures?

If you're submitting quality data via claims or a qualified registry and submit less than 6 measures or no outcome or high priority measure, we'll use the Eligibility Measure Applicability (EMA) process to see if you could have submitted more clinically related measures.

If we find that there are no applicable measures for you, you:

- Won't be held accountable for not submitting those measures.
- Will have a lower number of maximum points available in the Quality performance category.

Eligibility Measure Applicability (EMA) is:

- Based on evaluation of submitted measures and determination of clinically related measures aligned with specialty measure sets.
- Specific to the submission mechanism (i.e., EMA won't determine that a claims submitter had a registry measure available).
- Not applicable for EHR, QCDR, and Web Interface data submission mechanisms.

But, if we see that additional clinically-related measures could have been submitted and weren't, your maximum number of points available for the Quality performance category won't be reduced

Measure Bonus Points

What is the end-to-end reporting bonus?

You'll receive 1 bonus point per measure for reporting your quality data directly from your CEHRT to a Qualified Registry, QCDR, or via the CMS Web Interface. Those bonus points will be added to your or your group's or virtual group's Quality performance category achievement points (those earned based on performance). End-to-end bonus points will be added to your Quality performance category achievement points (those earned based on performance) and are capped at 10% of your Quality performance category denominator. Please refer to the 2018 MIPS Bonus Overview Fact Sheet for more information.

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

There are bonus points for submitting additional measures including 1 bonus point for each additional high priority measure, and 2 bonus points for each additional outcome and patient experience measure. Bonus points will be added to your or your group's/ virtual group's Quality performance category achievement points (those earned based on performance) and are capped at 10% of the Quality performance category denominator.

Please note, that this is separate from the 10% cap on the end-to-end reporting bonus. Bonus points are added to the Quality performance category achievement points (those earned based on performance) and can be earned in addition to the bonus points available for end-to end electronic reporting. Please refer to the 2018 MIPS Bonus Overview Fact Sheet for more information.

Improvement Scoring

Starting with the 2018 performance period, you can earn up to 10 percentage points based on the rate of your improvement in the Quality performance category from the year before. Bonus points will be incorporated into your or your group's/ virtual group's overall Quality performance category score.

How do we evaluate eligibility for improvement scoring?

You'll be evaluated for improvement scoring in 2018 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; 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 (2017 transition year); 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.

Here's how we'll compare data across identifiers:

Scenario	Current MIPS performance period identifier	Prior MIPS Performance Period Identifier (with score greater than zero)	Eligible for Improvement Scoring	Data Comparability
No change in identifier.	Individual (TIN A/NPI 1)	Individual (TIN A/NPI 1)	Yes	Current individual score is compared to individual score from prior performance period.
No change in identifier.	Group (TIN A)	Group (TIN A)	Yes	Current group score is compared to group score from prior performance period.
Individual is with same group but selects to submit as an individual whereas previously the group submitted as a group.	Individual (TIN A/NPI 1)	Group (TIN A)	Yes	Current individual score is compared to the group score associated with the TIN/NPI from the prior performance period.
Individual changes practices but submitted to MIPS previously as an individual.	Individual (TIN B/NPI)	Individual (TIN A/NPI 1)	Yes	Current individual score is compared to the individual score from the prior performance period.
Individual changes	Individual (TIN C/NPI)	Group (TIN A/NPI);	Yes	Current individual score

Scenario	Current MIPS performance period identifier	Prior MIPS Performance Period Identifier (with score greater than zero)	Eligible for Improvement Scoring	Data Comparability
practices and has multiple scores in prior performance period.		Individual (TIN B/NPI)		is compared to highest score from the prior performance period.
Group does not have a previous group score from prior performance period.	Group (TIN A/NPI)	Individual scores (TIN A/NPI 1, TIN A/NPI 2, TIN A/NPI 3, etc.)	Yes	The current group score is compared to the average of the scores from the prior performance period of individuals who comprise the current group.
Virtual group does not have previous group score from prior performance period.	Virtual Group (Virtual Group Identifier A) (Assume virtual group has 2 TINs with 2 clinicians.)	Individuals (TIN A/NPI 1, TIN A/NPI 2, TIN B/NPI 1, TIN B/NPI 2)	Yes	The current group score is compared to the average of the scores from the prior performance period of individuals who comprise the current group.
Individual has score from prior performance period as part of an APM Entity	Individual (TIN A/NPI 1)	APM Entity (APM Entity Identifier)	Yes	Current individual score is compared to the score of the APM entity from the prior performance period.

Scenario	Current MIPS performance period identifier	Prior MIPS Performance Period Identifier (with score greater than zero)	Eligible for Improvement Scoring	Data Comparability
Individual does not have a quality performance category achievement score for the prior performance period.	Individual (TIN A/NPI 1)	Individual was not eligible for MIPS and did not voluntarily submit any quality measures to MIPS.	No	The individual quality performance category score is missing for the prior performance period and not eligible for improvement scoring.

How is improvement scoring calculated?

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

Example:

In the transition year, a MIPS eligible clinician earned 25 measure achievement points and 2 measure bonus points for reporting an additional outcome measure.

For the 2018 performance period, the same MIPS eligible clinician earned 33 measure achievement points and 6 measure bonus points for end-to-end electronic reporting.

- 2017 Quality performance category achievement percent score = 42%

- (25/60)
- Excludes the 2 bonus points

- 2018 Quality performance category achievement percent score = 55%
  - (33/60)
  - Excludes the 6 bonus points
- The increase in Quality performance category achievement percent score from prior performance period to current performance period = 13%
  - (55% - 42%)
- The improvement percent score is 3.1% which will be added to the percent score earned for reported measures.
  - (13%/42%)*10% = 3.1%

To account for transition year policies that allowed clinicians to test their participation, MIPS eligible clinicians with a 2017 Quality performance category achievement percent score below 30% will be scored for improvement based on a 30% achievement percent score, which is the lowest score a MIPS eligible clinician can achieve with complete reporting in year 1. This policy allows us to score a MIPS eligible clinician on improvement and still account for differences in participation levels between the two years.

Please note that the improvement percent score cannot be negative and is capped at 10%.

Calculating the Quality Performance Category Percent Score

The quality performance category percentage score calculation was updated to reflect improvement scoring.

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

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

Data Accuracy

CMS believes it is important to ensure the Quality Payment Program is based on accurate and reliable data. Under MIPS, CMS will validate data on an ongoing basis. MIPS eligible clinicians, groups, or virtual groups may also be selectively audited by CMS.

If a MIPS eligible clinician, group, or virtual group is selected for audit, they would be required to comply with data sharing requests, providing all data as requested including primary source documentation. CMS may reopen and revise a MIPS payment adjustment as a result of the data validation or auditing process. CMS requires all MIPS eligible clinicians, groups, and virtual groups that submit data and information to CMS for purposes of MIPS to certify to the best of their knowledge that the data submitted to CMS is true, accurate, and complete. All MIPS eligible clinicians, groups, and virtual groups that submit data and information to CMS for MIPS must retain such data and information for 6 years from the end of the MIPS performance period.

Shaping the Future of Quality

Quality measure development and inclusion

In choosing future quality measures, based on stakeholder feedback, CMS looks for measures that are:

- Outcomes-based
- Applicable
- Feasible
- Scientifically defensible (MIPS quality measures only)
- Reliable
- Valid at the individual MIPS eligible clinician level
- Demonstrate a performance gap (room for improvement, not topped out)
- Not duplicative of existing measures and activities for notice and comment rulemaking

This means that a recommended list of new MIPS quality measures will be publicly available for comment for a period of time. CMS will evaluate public comments through the rulemaking process before making a final selection of new MIPS quality measures. Every year, a final list of quality measures for MIPS eligible clinicians will be published in the **Federal Register** no later than November 1 of the year, before the first day of a performance period.

The Quality performance category focuses on measures in the following six domains for future measure thought and selection:

- Patient safety
- Person and caregiver-centered experience and outcomes
- Communication and care coordination
- Effective clinical care
- Community/population health
- Efficiency and cost reduction

Annual Call for Quality Measures

Each year, CMS holds a Call for Measures that allows clinicians and organizations, including but not limited to those representing MIPS eligible clinicians (professional associations and medical societies) and other stakeholders (researchers and consumer groups), to submit quality measures for consideration.

Resources

- Information regarding the Annual Call for Measures and Activities and the Measures under Consideration (MUC) list, Measure Applications Partnership (MAP) and Pre-rulemaking.
- The eCQI Resource Center contains information regarding electronic clinical quality measures (eCQMs)
- Medicare Shared Savings Program Benchmarks (Applicable for CMS Web Interface users)
- MIPS APMs in the Quality Payment Program

For questions, contact the Quality Payment Program at 1-866-288-8292 (TTY 1-877-715- 6222), available Monday through Friday 8:00 AM-8:00 PM Eastern Time, or via e-mail at QPP@cms.hhs.gov